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CIVILIAN HEALTH AND MEDICAL PROGRAM  
OF THE UNIFORMED SERVICES (CHAMPUS)

The Assistant Secretary of Defense for Health Affairs has authorized the following page changes to DoD 601 O.8-R, "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," July 1991 (Reprint).

PAGE CHANGE


Remove: Pages 4-i through 4-67, 6-i through 6-36, 13-i through 13-37, and 14-i through 14-34

Insert: Attached replacement pages and new pages 4-68 through 4-81, 6-37 through 6-57, 13-38 through 13-44, and 14-35 through 14-38

EFFECTIVE DATES

The above changes are effective on or after:

1. Dental Benefit Plan retroactively back to April 1, 1993
2. Authorized Provider and Provider Reimbursement Methods, April 6, 1995
3. Basic Program Benefits, October 1, 1995

  
B.C. WHITEHEAD  
Director  
Correspondence and Directives

Attachments  
237 pages

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, THIS TRANSMITTAL SHOULD BE FILED WITH THE BASIC DOCUMENT

CHAPTER 4

BASIC PROGRAM BENEFITS

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CHAPTER 4  
BASIC PROGRAM BENEFITS

A. GENERAL

The CHAMPUS Basic Program is essentially a supplemental program to the Uniformed Services direct medical care- system. The Basic Program is similar to private medical insurance programs, and is designed to provide financial assistance to CHAMPUS beneficiaries for certain prescribed medical care obtained from civilian sources.

1. Scope of benefits. Subject to all applicable definitions, conditions, limitations, or exclusions specified in this Regulation, the CHAMPUS Basic Program will pay for medically necessary services and supplies required in the diagnosis and treatment of illness or injury, including maternity care and well-baby care. Benefits include specified medical services and supplies provided to eligible beneficiaries from authorized civilian sources such as hospitals, other authorized institutional providers, physicians, other authorized individual professional providers, and professional ambulance service, prescription drugs, authorized medical supplies, and rental or purchase of durable medical equipment.

2. Persons eligible for Basic Program benefits. Persons eligible to receive the Basic Program benefits are set forth in Chapter 3 of this Regulation. Any person determined to be an eligible CHAMPUS beneficiary is eligible for Basic Program benefits.

3. Authority to act. for CHAMPUS. The authority to make benefit **determinations** and authorize the disbursement of funds under CHAMPUS is restricted to the Director, OCHAMPUS; designated OCHAMPUS staff; Director, OCHAMPUSEUR; or CHAMPUS fiscal intermediaries. No other persons or agents (such as physicians, staff members of hospitals, or CHAMPUS health benefits advisors) have such authority.

4. Status of patient controlling for purposes of cost-sharing. Benefits for covered services **and supplies** described in this chapter will be extended either on an inpatient or outpatient cost-sharing basis in accordance with the status of the patient at the time the covered services and supplies were provided, unless otherwise specifically designated (such as for ambulance service or maternity care). For cost-sharing provisions, refer to section F. of this chapter.

5. Right to information. As a condition precedent to the provision of benefits hereunder, OCHAMPUS or its CHAMPUS fiscal intermediaries shall be entitled to receive information from a physician or hospital **or** other person, institution, or organization (including a local, state, or U.S. Government agency) providing services or supplies to the beneficiary for which claims or requests for approval for benefits are submitted. Such information and records may relate to the attendance, testing, monitoring, or examination or diagnosis of, or treatment rendered, or services and supplies furnished to a beneficiary, and shall be necessary for the accurate and efficient administration of CHAMPUS benefits. Before a determination will be made on a request for **preauthorization** or claim of benefits, a beneficiary or sponsor must provide particular additional information relevant to the requested determina-

tion, when necessary. The recipient of such information shall in every case hold such records confidential except. when (a) disclosure of such information is authorized specifically by the beneficiary; (b) disclosure is necessary to permit authorized **governmental** officials to investigate and prosecute criminal actions, or (c) disclosure is authorized or required specifically under the terms of the Privacy Act or Freedom of Information Act (references (i) through (k)) (refer to section M. of chapter 1 of this Regulation). For the purposes of determining the applicability of and implementing the provisions of chapters 8, 11 and 12, or any provision of similar purpose of any other medical benefits coverage or entitlement, **OCHAMPUS** or **CHAMPUS** fiscal intermediaries may release, without consent or notice to any beneficiary or sponsor, to any person, organization, government agency, provider, or other entity any information with respect. to any beneficiary when such release constitutes a routine use published in the Federal Register in accordance with DoD 5400.11-R (reference (k)). Before a person's claim of benefits will be adjudicated, the person must furnish to **CHAMPUS** information that reasonably may be expected to be in his or her possession and that is necessary to make the benefit determination. Failure to provide the requested information may result in denial of ~~the~~ claim.

6. Physical examinations. The Director, **OCHAMPUS**, or a designee, may require a beneficiary to submit to one or more medical (including psychiatric) examinations to determine the beneficiary's entitlement to benefits for which application has been made or for otherwise authorized medically necessary services and supplies required in the diagnosis or treatment of an illness or injury (including maternity and well-baby care). When a medical examination has been requested, **CHAMPUS** will withhold payment of any pending claims or preauthorization requests on that particular beneficiary. If the beneficiary refuses to agree to the requested medical examination, or unless prevented by a medical reason acceptable to **OCHAMPUS**, the examination is not performed within 90 days of initial request, all pending claims for services and supplies **will** be denied. A denial of payments for services or supplies provided before (and related to) the request for a physical examination is not subject to reconsideration. The medical examination and required beneficiary travel related to performing the requested medical examination will **be** at the **expense** of **CHAMPUS**. The medical examination may be performed by a physician in a Uniformed Services medical facility or by an appropriate civilian physician, as determined and selected by the Director, **OCHAMPUS**, or a designee who is responsible for making such arrangements as are necessary, including necessary travel arrangements.

7. Claims filing deadline. For all services provided on or after January 1, 1993, to be considered for benefits, all claims submitted for benefits, must, except as provided in Chapter 7, of this regulation, be filed with the appropriate **CHAMPUS** contractor no later than one year after the services are provided. Unless the requirement is waived, failure to file a claim within the deadline waives all rights to benefits for such services or supplies.

8. Double coverage and third party recoveries. **CHAMPUS** claims involving double coverage or the possibility that the United States can recover all or a part of its expenses from a third party, are specifically subject to the provisions of Chapter 8 or Chapter 12 of this Regulation as appropriate.

9. Nonavailability Statements within a 60-mile catchment area. In some 1  
geographic locations (or under certain special **circumstances**), it is necessary for a  
CHAMPUS beneficiary to determine whether the required medical care can be provided  
through a Uniformed Service facility. If the required medical care cannot be  
provided, the hospital commander, or a designee, will issue a **Nonavailability**  
Statement (DD Form 1251). Except for emergencies, a **Nonavailability** State-  
ment should be issued before medic-al care is obtained from a civilian  
source. Failure to secure such a statement may waive the beneficiary's  
rights to benefits under CHAMPUS.

a. Rules applicable to issuance of Nonavailability Statement (DD  
Form 1251).

(1) The ASD(HA) is responsible for issuing rules and regulations  
regarding **Nonavailability** Statements.

(2) A **Nonavailability** Statement (NAS) is required for services in  
connection with nonemergency inpatient hospital care if such **services** are available  
at a facility of the Uniformed Services located within a 40-mile radius of the  
residence of the beneficiary, except that a NAS is not required for services  
otherwise available at a facility of the Uniformed Services located within a 40-mile  
radius of the beneficiary's residence when another insurance plan or program  
provides the beneficiary primary coverage for the services.

(3) An NAS is also required for selected outpatient procedures if  
such services are not available at a Uniformed Service facility (excluding  
facilities which are exclusively outpatient clinics) located within a 40-mile radius  
(**catchment** area) of the residence of the beneficiary. This does not apply to  
emergency services or for services for which another insurance plan or program  
provides the beneficiary primary coverage. Any changes to the selected outpatient  
procedures will be published in the Federal Register at least 30 days before the  
effective date of the change by the ASD(HA) and will be limited to the following  
categories: outpatient surgery and other selected outpatient procedures which have  
high unit costs and for which care may be, available in military treatment facilities  
generally. The selected outpatient procedures will be uniform for all CHAMPUS  
beneficiaries.

(4) In addition to NAS requirements set forth in paragraph A.9, of  
this chapter, additional NAS requirement.s are established pursuant to paragraph  
A.10, of this chapter in connection with highly specialized care in national or 200  
mile catchrnt areas of military or civilian Specialized Treatment Services  
Facilities.

b. Beneficiary responsibility. The beneficiary is responsible for  
securing information whether or not he or she resides in a geographic area that  
requires obtaining a **Nonavailability** Statement. Information concerning current  
rules and regulations may be obtained from the Offices of the Army, Navy, and Air  
Force Surgeon Generals; or a CHAMPUS health benefits advisor; or the Director,  
OCHAMPUS, or a designee; or from the appropriate CHAMPUS fiscal intermediary.

c. Rules in effect at time civilian medical care is provided apply.  
The applicable rules and regulations regarding **Nonavailability** Statements in effect  
at the time the civilian care is rendered apply in determining whether a  
**Nonavailability** Statement is required.

d. Nonavailability Statement (DD Form 1251) must be filed with applicable claim. When a claim is submitted for CHAMPUS benefits that includes services for which a Nonavailability Statement was issued, a valid Nonavailability Statement authorization must be on **DEERS**.

e. Nonavailability Statement (NAS) and claims adjudication.

(1) A NAS is **valid** for the adjudication of CHAMPUS claims for all related care otherwise authorized by this Regulation which is received from a civilian source while the beneficiary resided within the Uniformed Service facility **catchment** area which issued the NAS.

(2) A requirement for a NAS for inpatient hospital maternity care must be met for CHAMPUS **cost-share** of any related outpatient maternity care.

10. Nonavailability Statements in national or 200-mile catchment areas for highly specialized care available in selected military or civilian Specialized Treatment Service Facilities.

a. Specialized Treatment Service Facilities. STS Facilities may be designated for certain high cost, high technology procedures. The purpose of such designations is to concentrate patient referrals for certain highly specialized procedures which are of relatively low incidence and/or relatively high per case cost and which require patient concentration to permit resource investment and enhance the effectiveness of quality assurance efforts.

b. Designation. Selected military treatment facilities and civilian facilities will be designated by the Assistant Secretary of Defense for Health Affairs as STS Facilities for certain procedures. These designations will be based on the highly specialized capabilities of these selected facilities. For each STS designation for which NASS in national or 200-mile **catchment** areas will be required, there shall be a determination that total government costs associated with providing the service under the Specialized Treatment Services program will in aggregate be less than the total government cost of that service under the normal operation of CHAMPUS. There shall also be a **determination** that the Specialized Treatment Services Facility meets a standard of excellence in quality comparable to that prevailing in other specialized medical centers in the nation or region that provide the services involved.

c. Organ transplants and similar procedures. For organ transplants and procedures of similar extraordinary specialization, military or civilian STS Facilities may be designated for a nationwide catchment area, covering all 50 states, the District of Columbia and Puerto Rico (or, alternatively, for any portion of such a nationwide area).

d. Other highly specialized procedures. For other highly specialized procedures, military or civilian STS Facilities will be designated for catchment areas of up to approximately 200 miles radius. The exact geographical area covered for each STS Facility will be identified by reference to State and local

governmental jurisdictions, zip code groups or other method to describe an area within an approximate radius of 200 miles from the facility. In paragraph **A.10** of this chapter, this **catchment** area is referred to as a "200-mile **catchment** area".

e. NAS requirement. For procedures subject to a nationwide catchment area NAS requirement under paragraph A.10.C of this chapter or a 200-mile **catchment** area NAS requirement under **paragraph A.10.d** of this chapter CHAMPUS cost sharing is not allowed unless the services are obtained from a designated civilian Specialized Treatment Services program (as authorized) or an NAS has been issued. This rule is subject to the exception set forth in paragraph **A.10.f** of this chapter. This NAS requirement is a general requirement of the CHAMPUS program.

f. Exceptions. Nationwide **catchment** area NASS and 200-mile catchment area NASS are not required in any of the following circumstances:

(1) An emergency.

(2) When another insurance plan or program provides the beneficiary primary coverage for the services.

(3) A case-by-case waiver is granted based on a medical judgment made by the commander of the STS Facility (**or** other person designated for this purpose) that, although the care is available at the facility, it would be medically inappropriate because of a delay in the treatment or other special reason to require that the STS Facility be used; or

(4) A case-by-case waiver is granted by the commander of the STS Facility (**or** other person designated for this purpose) that, although the care is available at the facility, use of the facility would impose exceptional hardship on the beneficiary or the beneficiary's family.

g. Waiver process. A process shall **be** established for beneficiaries to request a case-by-case waiver under paragraphs **A.10.f.** (3)(4) of this chapter. This process shall include:

(1) An opportunity for the beneficiary (and/or the beneficiary's physician) to submit information the beneficiary believes justifies a waiver.

(2) A written decision from a person designated for the purpose on the request for a waiver, including a statement of the reasons **for** the decision.

(3) An opportunity for the beneficiary to appeal an unfavorable decision to a designated appeal authority not involved in the initial decision; and

(4) A written decision on the appeal, including a statement of the reasons for the decision.

h. Notice. The Assistant Secretary of Defense for Health Affairs will annually publish in the Federal Register a notice of all military and civilian STS Facilities, including a listing of the several procedures subject to nationwide **catchment** area NASS and the highly specialized procedures subject to **200-mile catchment** area NASSs.

i. Specialized procedures. Highly specialized procedures that may be established as subject to 200-mile **catchment** area NASS are limited to:

(1) Medical and surgical diagnoses requiring inpatient hospital treatment of an unusually intensive nature, documented by a **DRG-based** payment system weight (pursuant to Chapter 14, paragraph A1) for a single DRG or an aggregated DRG weight for a category of DRGs of at least 2.0 (i.e., treatment is at least two times as intensive as the average CHAMPUS inpatient case).

(2) Diagnostic or therapeutic services, including outpatient services, related to such inpatient categories of treatment.

(3) Other procedures which require highly specialized equipment the cost of which exceeds \$1,000,000 (e.g., lithotripter, positron emission tomography equipment) and such equipment is underutilized in the area; and

(4) Other comparable highly specialized procedures as determined by the Assistant Secretary of Defense for Health Affairs.

j. Quality standards. Any facility designated as a military or civilian STS Facility under paragraph A.10 of this chapter shall be required to meet quality standards established by the Assistant Secretary of Defense for Health Affairs. In the development of such standards, the Assistant Secretary shall consult with relevant medical speciality societies and other appropriate parties. To the extent feasible, quality standards shall be based on nationally recognized standards.

k. NAS procedures. The provisions of paragraphs A.9.b through A.9.e of this chapter regarding procedures applicable to NASS shall apply to expanded catchment area NASS required by paragraph A.10 of this chapter.

l. Travel and lodging expenses. In accordance with guidelines issued by the Assistant Secretary of Defense for Health Affairs, certain travel and lodging expenses associated with services under the Specialized Treatment Services program may be fully or partially reimbursed.

m. Preference for military facility use. In any case in which services subject to an NAS requirement under paragraph A.10 of this chapter are available in both a military STS Facility and from a civilian STS Facility, the military Facility must be used unless use of the civilian Facility is specifically authorized.

11. Quality and Utilization Review Peer Review Organization program. All benefits under the CHAMPUS program are subject to review under the CHAMPUS Quality and Utilization Review Peer Review Organization program pursuant to Chapter 15. Utilization and quality review of mental health services are also part of the Peer Review Organization program, and are addressed in paragraph A.12 of this chapter.)

12. Utilization review, quality assurance and preauthorization for inpatient mental health services.

a. In general. The Director, OCHAMPUS shall provide, either directly or through contract, a Program of utilization and quality review for all mental health care services. Among other things, this program shall include mandatory



preadmission authorization before **nonemergency** inpatient mental health services may be provided and mandatory approval of continuation of inpatient services within 72 hours of emergency admissions. This program shall also include requirements **for** other pretreatment authorization procedures, concurrent review of continuing inpatient and partial hospitalization care, retrospective review, and other such procedures as determined appropriate **by** the Director, **OCHAMPUS**. The provisions of paragraph H of **this chapter** and paragraph F, Chapter 15, shall apply to this program. The Director, **OCHAMPUS**, shall establish, pursuant to paragraph F., Chapter 15, procedures substantially comparable to requirements of paragraph H of this chapter and Chapter 15. If the utilization and quality review program for mental health care services is provided **by** contract, the contractor(s) need not be the same contractor(s) as are engaged under Chapter 15 in connection with the review of other services.

**b. Preadmission authorization.**

(1) This section generally requires preadmission authorization for all nonemergency inpatient mental health services and prompt continued stay authorization after emergency admissions. It also requires preadmission authorization for all admissions to a partial hospitalization program, without exception, as the concept of an emergency admission does not pertain to a partial hospitalization level of care. Institutional services **for** which payment would otherwise be authorized, but which were provided without compliance with preadmission authorization requirements, do **not** qualify for the same payment that would **be** provided if the preadmission requirements had been met.

(2) In cases of noncompliance with preauthorization requirements, a payment reduction **shall be** made in accordance with Chapter **15**, paragraph **B.4.c**.

(3) For purposes of paragraph **A.12.b. (2)** of this chapter, a day of services without the appropriate preauthorization is any day of services provided prior to:

(a) the receipt of an authorization; or

(b) the effective date of an authorization subsequently received.

(4) Services for which payment is disallowed under paragraph **A.12.b. (2)** of this chapter may not be billed to the patient (or the patient's family).

13. **Implementing instructions.** The Director, **OCHAMPUS**, shall issue policies, procedures, instructions, guidelines, standards, **and/or** criteria to implement this chapter.

**B. INSTITUTIONAL BENEFITS**

1. **General.** Services and supplies provided by an institutional provider authorized as set forth in Chapter 6 of this Regulation may be cost-shared only when such services or supplies (i) are otherwise authorized by this Regulation; (ii) are medically necessary; (iii) are ordered, directed, prescribed, or delivered by an

**CHAMPUS-authorized** individual professional provider as set forth in Chapter 6 of this Regulation or by an employee of the authorized institutional provider who is otherwise eligible to be a CHAMPUS authorized individual professional provider; (iv) are delivered in accordance with generally accepted norms for clinical practice in the United States; (v) meet established quality standards; and (vi) comply with applicable definitions, conditions, limitations, exceptions, or exclusions as otherwise set forth **in this** Regulation-.

a. Billing practices. To be considered for benefits under this section B., covered services and supplies must **be** provided and billed for **by** a hospital or other authorized institutional provider. Such billings must be fully itemized and sufficiently descriptive to permit CHAMPUS to determine whether benefits are authorized by this Regulation. Depending on the individual circumstances, teaching physician services may be considered an institutional benefit in accordance with this Section **or** a professional benefit under Section C. See paragraph **C.3.m.** of the Chapter for the CHAMPUS requirements regarding teaching physicians. In the case of continuous care, claims shall be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days either by the beneficiary or sponsor or, on a participating basis, directly by the facility on behalf of the beneficiary (refer to Chapter 7).

b. Successive **inpatient** admissions. Successive inpatient admissions shall be deemed one inpatient confinement for the purpose of computing the active duty dependent's share of the inpatient institutional charges, provided not more than 60 days have elapsed between the successive admissions, except that successive inpatient admissions related to a single maternity episode shall be considered one confinement, regardless of the number of days between admissions. For the purpose of applying benefits, successive admissions will be determined separately for maternity admissions and admissions related to an accidental injury (refer to section F. of this chapter).

c. Related services and **supplies**. Covered services and supplies must be rendered in connection with and related directly to a covered diagnosis or definitive set of symptoms requiring otherwise authorized medically necessary treatment.

d. **Inpatient, appropriate level required.** For purposes of inpatient care, the level of institutional care for which Basic Program benefits may be extended must **be** at the appropriate level required to provide the medically necessary treatment except for patients requiring skilled nursing facility care. For patients for whom skilled nursing facility care is adequate, but is not available in the general locality, benefits may be continued in the higher level care facility. General locality means an area that includes all the skilled nursing facilities within 50 miles of the higher level facility, unless the higher level facility can demonstrate that the skilled nursing facilities are inaccessible to its patients. The decision as to whether a skilled nursing facility is within the higher level facility's general locality, or the skilled nursing facility is inaccessible to the higher level facility's patients shall **be** a CHAMPUS contractor initial determination for the purposes of appeal under chapter 10 of this regulation. CHAMPUS institutional benefit payments shall **be** limited to the

allowable cost that would have been incurred in the skilled nursing facility, as determined by the Director, **OCHAMPUS**, or a designee. If it is determined that the institutional care can be provided reasonably in the home setting, no CHAMPUS institutional benefits are payable.

e. General or special education not covered. Services and supplies related to the provision of either **regular** or special-education generally are not covered. Such exclusion applies whether a separate charge is made for education or whether it is included as a part of an overall combined daily charge of an institution. In the latter instance, that portion of the overall combined **daily** charge related to education must be determined, based on the allowable costs of the educational component, and deleted from the institution's charges before CHAMPUS benefits can be extended. The only exception is when appropriate education is not available from or not payable by the cognizant public entity. Each case must be referred to the Director, **OCHAMPUS**, or a designee, for review and a determination of the applicability of CHAMPUS benefits.

2. Covered hospital services and supplies

a. Room and board. Includes special diets, laundry services, and other general housekeeping **support** services (inpatient only).

b. General staff nursing services.

c. Icu. Includes specialized units, such as for respiratory conditions, cardiac surgery, coronary care, burn care, or neurosurgery (inpatient only) .

d. Operating room, recovery room. Operating room and recovery room, including other special treatment **rooms** and equipment, and hyperbaric chamber.

e. Drugs and medicines. Includes sera, biological, and **pharmaceutical** preparations (**including** insulin) that are listed in the official **formularies** of the institution or facility at the time of use. (To be considered as an inpatient supply, drugs and medicines must be consumed during the specific period the beneficiary is a registered inpatient. Drugs and medicines prescribed for use outside the hospital, even though prescribed and obtained while still a registered inpatient, will be considered outpatient supplies and the provisions of section D. of this chapter will apply.)

f. Durable medical equipment, medical supplies, and dressings. Includes durable medical equipment, medical supplies essential to a surgical procedure (such as artificial heart valve and artificial ball and socket joint), sterile trays, casts, and orthopedic hardware. Use of durable medical equipment is restricted to an inpatient basis.

NOTE : If durable medical equipment is to be used on an outpatient basis or continued in outpatient status after use as an inpatient, benefits will be provided as set forth in section D. of this chapter and cost-sharing will be on an outpatient basis (refer to subsection A.4. of this chapter).

g. Diagnostic services. Includes clinical laboratory examinations, x-ray examinations, pathological examinations, and machine tests that produce hard-copy results. Also includes CT scanning under certain limited conditions.

h. Anesthesia. Includes both the anesthetic agent and its administration.

i. Blood. Includes blood, plasma and its derivatives, including equipment and supplies, and its administration.

j. Radiation therapy. Includes radioisotopes.

k. Physical therapy.

l. Oxygen. Includes equipment for its administration.

m. Intravenous injections. Includes solution.

n. Shock therapy.

o. Chemotherapy.

p. Renal and peritoneal dialysis.

q. Psychological evaluation tests. When required by the diagnosis.

r. Other medical services. Includes such other medical services as may be authorized by the Director, OCHAMPUS, or a designee, provided they are related directly to the diagnosis or definitive set of symptoms and rendered by a member of the institution's medical or professional staff (either salaried or contractual) and billed for by the hospital.

3. Covered services and supplies provided by special medical treatment institutions or facilities, other than hospitals or RTCS

a. Room and board. Includes special diets, laundry services, and other general housekeeping support services (inpatient only).

b. General staff nursing services.

c. Drugs and medicines. Includes sera, biological, and pharmaceutical preparations (including insulin) that are listed in the official formularies of the institution or facility at the time of use. (To be considered as an inpatient supply, drugs and medicines must be consumed during the specific period the beneficiary is a registered inpatient. Drugs and medicines prescribed for use outside the authorized institutional provider, even though prescribed and obtained while still a registered inpatient, will be considered outpatient supplies and the provisions of section D. of this chapter will apply.)

d. Durable medical equipment, medical supplies, and dressings. Includes durable medical equipment, sterile trays, casts, orthopedic hardware and dressings. Use of durable medical equipment is restricted to an inpatient basis.

NOTE : If the durable medical equipment is to be used on an outpatient basis or continued in outpatient status after use as an inpatient, benefits will **be** provided as set forth in section D. of this chapter, and cost-sharing will be **on** an outpatient basis (refer to subsection A.4. of this chapter) .

e. Diagnostic services. Includes clinical laboratory examinations, x-ray examinations, pathological examinations, and machine tests that produce hard-copy results.

f. Blood. Includes blood, plasma and its derivatives, including equipment and supplies, and its administration.

g. Physical therapy.

h. Oxygen. Includes equipment for its administration.

i. Intravenous infections. Includes solution.

j. Shock therapy.

k. Chemotherapy.

l. Psychological evaluation tests. When required by the diagnosis.

m. Renal and peritoneal dialysis.

n. Other medical services. Other medical services may be authorized by the Director, **OCHAMPUS**, or a designee, provided they are related directly to the diagnosis or definitive set of symptoms and rendered by a member of the institution's medical or professional staff (either salaried or contractual) and billed for by the authorized institutional provider of care.

#### 4. Services and supplies provided by RTCS

a. Room and board. Includes use of residential facilities such as food service (including **special** diets), laundry services, supervised **reasonable** recreational and social activity services, and other general services as considered appropriate by the Director, **OCHAMPUS**, or a designee.

b. Patient assessment. Includes the assessment of each child or adolescent accepted by the RTC, **including** clinical consideration of each of his or her fundamental needs, **that** is, physical, psychological, chronological age, developmental level, family, educational, social, environmental, and recreational.

c. Diagnostic services. Includes clinical laboratory examinations, x-ray **examinations**, pathological examinations, and machine tests that produce hard-copy results.

d. Psychological evaluation tests.

e. Treatment of mental disorders. Services and supplies that are medically or psychologically necessary to diagnose and treat the mental disorder **for** which the patient was admitted to the RTC. Covered services and requirements for qualifications of providers are as listed in paragraph **C.3.i.** of this chapter.

f. Other necessary medical care. Emergency medical services or other authorized **medical care** may **be** rendered **by** the RTC provided it is professionally **capable** of rendering such services and meets standards required by the Director, **OCHAMPUS**. It is intended, however, that CHAMPUS payments to an RTC should primarily cover those services and supplies directly related to the treatment of mental disorders that require residential care.

g. Criteria for determining medical or psychological necessity. In determining the medical or psychological necessity of services and supplies provided **by** RTCS, the evaluation conducted by the Director, **OCHAMPUS** (or designee) shall consider the appropriate level of care for the patient, the intensity of services required by the patient, and the availability of that care. In addition to the criteria set forth in this paragraph B.4. of this chapter, additional evaluation standards, consistent with such criteria, may be adopted by the Director, **OCHAMPUS** (or designee). RTC services and supplies shall not **be** considered medically or psychologically necessary unless, at a minimum, all the following criteria are clinically determined in the evaluation to be fully met:

(1) Patient has a diagnosable psychiatric disorder.

(2) Patient exhibits patterns of disruptive behavior with evidence of disturbances in family functioning or social relationships and persistent psychological and/or emotional disturbances.

(3) RTC services involve active clinical treatment under an individualized treatment plan that provides for:

(a) Specific level of care, and measurable goals/objectives relevant to each of the problems identified;

(b) Skilled interventions by qualified mental health professionals to assist the patient **and/or** family;

(c) Time frames for achieving proposed outcomes; and

(d) Evaluation of treatment progress to include timely reviews and updates as appropriate of the patient's treatment plan that reflects alterations in the treatment regimen, the measurable goals/objectives, and the level of care required for each of the patient's problems, and explanations of any failure to achieve the treatment goals/objectives.

(4) Unless therapeutically contraindicated, the family and/or guardian must actively participate in the continuing care of the patient either through direct involvement at the facility or geographically distant family therapy. (In the latter case, the treatment center must document that there has been collaboration with the family **and/or** guardian in all reviews.)

h. Preauthorization requirement.

(1) All admissions to RTC care are elective and must be certified as medically/psychologically necessary prior to admission. The criteria for preauthorization shall be those set forth in paragraph **B.4.g.** of this chapter. In applying those criteria in the context of preadmission authorization review, special emphasis is placed on the development of a specific diagnosis/treatment plan, consistent with those criteria and reasonably expected to **be** effective, for that individual patient.

(2) The timetable for development of the individualized treatment plan shall be as follows:

(a) The plan must be under development at the time of the admission.

(b) A preliminary treatment plan must be established within 24 hours of the admission.

(c) A master treatment plan must be established within ten calendar days of the admission.

(3) The elements of the individualized treatment plan must include:

(a) The diagnostic evaluation that establishes the necessity for the admission;

(b) An assessment regarding the inappropriateness of services at a less intensive level of care;

(c) A comprehensive, **biopsychosocial** assessment and diagnostic formulation;

(d) A specific individualized treatment plan that integrates measurable goals/objectives and their required level of care for each of the patient's problems that are a focus of treatment;

(e) A specific plan for involvement of family members, unless therapeutically contraindicated; and

(f) A discharge plan, including an objective of referring the patient to further services, if needed, at less intensive levels of care within the benefit limit period.

(4) **Preauthorization** requests should be made not fewer than two business days prior to the planned admission. In general, the decision regarding preauthorization shall **be** made within one business day of receipt of a request for preauthorization, and shall be followed with written confirmation. **Pre-**aut.horizations are valid for the period of time, appropriate to the type of care involved, stated when the **preauthorization** is issued. In general, **pre-**authorizations are valid for 30 **days**.

i . Concurrent review. Concurrent. review of the necessity for continued stay will be conducted no less frequently than every 30 days. The criteria for concurrent review shall be those set forth in paragraph **B.4.g.** of this chapter. In applying those criteria in the context **of** concurrent review, special emphasis is placed on evaluating the progress being made in the active individualized clinical treatment being provided and on developing appropriate discharge plans.

5. Extent of institutional benefits

a. Inpatient room accommodations

(1) Semiprivate. The allowable costs for room and board furnished an individual patient are payable for semiprivate accommodations in a hospital or other authorized institution, subject to appropriate cost-sharing provisions (refer to section F. of this chapter). A semiprivate accommodation is a room containing at least two beds. Therefore, if a room publicly is designated by the institution as a semiprivate accommodation and contains multiple beds, it qualifies as semiprivate for the purpose of CHAMPUS.

(2) Private. A room with one bed that is designated as a private room by the hospital or other authorized institutional provider. The allowable cost of a private room accommodation is covered only under the following conditions:

(a) When its use is required medically and when the attending physician certifies that a private room is necessary medically for the proper care and treatment of a patient; or

(b) When a patient's medical condition requires isolation;  
or

(c) When a patient (in need of immediate inpatient care but not requiring a private room) is admitted to a hospital **or** other authorized institution that has semiprivate accommodations, but at the time of admission, such accommodations are occupied; or

(d) When a patient is admitted to an acute care hospital (general or special) without semiprivate **rooms**.

(3) Duration of private room stay. The **allowable cost** of private accommodations is covered under the circumstances described in subparagraph **B.5.a.** (2) of this chapter until the patient's condition no longer requires the private room for medical reasons or medical isolation; or, in the case



of the patient not requiring a private room, when a semiprivate **accommoda-**  
tion becomes available; or, in the case of an acute care hospital (general  
or special) which does not have semiprivate rooms, for the duration of an  
otherwise covered inpatient stay.

(4) Hospital (except an acute care hospital, general or spe-  
cial) or other authorized institutional provider without semiprivate accom-  
modations. When a beneficiary is admitted to a hospital (except an acute  
care hospital, general or special) or other institution that has no semi-  
private accommodations, for **any inpatient** day when the patient qualifies for  
use of a private room (as set forth in subparagraphs **B.5.a.** (2)(a) and (b),  
above), the allowable cost of private accommodations is covered. For any  
inpatient day in such a hospital or other authorized institution when the  
patient does not require medically the private room, the allowable cost of  
semiprivate accommodations is covered, such allowable costs to be determined  
by the Director, **OCHAMPUS**, or a designee.

b. General staff nursing services. General staff nursing services  
cover all nursing care (other than that provided by private duty nurses) in-  
cluding, but not limited to, general duty nursing, emergency room nursing,  
recovery room nursing, intensive nursing care, and group nursing arrange-  
ments. Only nursing services provided by nursing personnel on the payroll  
of the hospital or other authorized institution are eligible under this  
section B. If a nurse who is not on the payroll of the hospital or other  
authorized institution is called in specifically to care for a single  
patient (individual nursing) or more than one patient (group nursing),  
whether the patient is billed for the nursing services **directly or** through  
the hospital or other institution, such services constitute private duty  
(special) nursing services and are not eligible for benefits under this  
paragraph (the provisions of paragraph **C.2.o.** of this chapter would apply).

c. **ICU.** An ICU is a special segregated unit of a hospital in which  
patients are concentrated, by reason of serious illness, usually without  
regard to diagnosis. Special lifesaving techniques and equipment are avail-  
able regularly and immediately within the unit, and patients are under contin-  
uous observation by a nursing staff specially trained and selected for the  
care of this type of patient. The unit is maintained on a continuing, rather  
than an intermittent or temporary, basis. It is not a postoperative recovery  
room or a postanesthesia room. In some large or highly specialized hospitals,  
the ICUS may be refined further for special purposes, such as for respiratory  
conditions, cardiac surgery, coronary care, burn care, or neurosurgery. For  
purposes of CHAMPUS, these specialized units would be considered ICUS if they  
otherwise conformed to the definition of an ICU.

d. Treatment rooms. Standard treatment. rooms include emergency  
rooms, operating rooms, recovery rooms, special treatment rooms, and hyper-  
baric chambers and all related necessary medical staff and equipment. To be  
recognized for purposes of CHAMPUS, treatment rooms must **be** so designated and  
maintained by the hospital **or** other authorized institution on a continuing  
basis. A treatment room set up on an intermittent or temporary basis would  
not **be so** recognized.

e. Drugs and medicines. Drugs and medicines are included as a supply of a hospital or other authorized institution only under the following conditions:

- (1) They represent a cost to the facility rendering treatment;
- (2) They are furnished to a patient receiving treatment, and are related directly to that treatment; and
- (3) They are ordinarily furnished by the facility for the care and treatment of inpatients.

f. Durable medical equipment, medical supplies, and dressings. Durable medical equipment, medical supplies, and dressings are included as a supply of a hospital or other authorized institution only under the following conditions:

- (1) If ordinarily furnished by the facility for the care and treatment of patients; and
- (2) If specifically related to, and in connection with, the condition for which the patient is being treated; and
- (3) If ordinarily furnished to a patient for use in the hospital or other authorized institution (except in the case of a temporary or disposable item); and
- (4) Use of durable medical equipment is limited to those items provided while the patient is an inpatient. If such equipment is provided for use on an outpatient basis, the provisions of section D. of this chapter apply.

g. Transitional use items. Under certain circumstances, a temporary or disposable item may be provided for use beyond an inpatient stay, when such item is necessary medically to permit or facilitate the patient's departure from the hospital or other authorized institution, or which may be required until such time as the patient can obtain a continuing supply; or it would be unreasonable or impossible from a medical standpoint to discontinue the patient's use of the item at the time of termination of his or her stay as an inpatient.

h. Anesthetics and oxygen. Anesthetics and oxygen and their administration are considered a service or supply if furnished by the hospital or other authorized institution, or by others under arrangements made by the facility under which the billing for such services is made through the facility.

6. Inpatient mental health services. Inpatient mental health services are those services furnished by institutional and professional providers for treatment of a nervous or mental disorder (as defined in Chapter 2) to a

patient admitted to a **CHAMPUS-authorized** acute care general hospital; a psychiatric hospital; or, unless otherwise exempted, a special institutional provider.

a. Criteria for determining medical or psychological necessity. In determining the medical or psychological necessity of acute inpatient mental health services, the evaluation conducted **by** the Director, **OCHAMPUS** (or designee) shall consider the appropriate level of care for the patient, the intensity of services required **by** the patient, and the availability of that care. The purpose of such acute inpatient care is to stabilize a life-threatening or severely disabling condition within the context of a brief, intensive model of inpatient care in order to permit management of the patient's condition at a less intensive level of care. Such care is appropriate only if the **patient** requires services of an intensity and nature that are generally recognized as being effectively and safely provided only in **an acute** inpatient hospital setting. In addition to the criteria set forth in this paragraph B.6. of this chapter, additional evaluation standards, consistent with such criteria, may be adopted by the Director, **OCHAMPUS** (or designee) . Acute inpatient care shall not be considered necessary unless the patient needs to be observed and assessed on a 24-hour basis by skilled nursing staff, and/or requires continued intervention by a multidisciplinary treatment team; and in addition, at least one of the following criteria is determined to be met:

(1) Patient poses a serious risk of harm to self and/or others.

(2) Patient is in need of high dosage, intensive medication or somatic **and/or** psychological treatment, with potentially serious side effects.

(3) Patient has acute disturbances of mood, behavior, or thinking.

b. Emergency admissions. Admission to an acute inpatient hospital setting may be on an emergency or on a non-emergency basis. In order for an admission to qualify as an emergency, the following criteria, in addition to those in paragraph **B.6.a.** of this chapter, must be met:

(1) the patient must be at immediate risk of serious harm **to** self and or others based on a psychiatric evaluation performed by a physician (or other qualified mental health professional with hospital admission authority); and

(2) the patient requires immediate continuous skilled observation and treatment at the acute psychiatric level of care.

c. Preauthorization requirements.

(1) All non-emergency admissions to an acute inpatient hospital level of care must be authorized prior to the admission. The criteria for **preauthorization** shall be those set forth in paragraph **B.6.a.** of this chapter. In applying those criteria in the context of **preauthorization** review, special emphasis is placed on the development of a specific individualized treatment plan, consistent with those criteria and reasonably expected to be effective, for that individual patient.

(2) The timetable for development of the individualized treatment plan shall **be** as follows:

(a) The development of the plan must begin immediately upon admission.

(b) A preliminary treatment plan must be established within 24 hours of the admission.

(c) A master treatment plan must be established within five calendar days of the admission.

(3) The elements of the individualized treatment plan must include:

(a) The diagnostic evaluation that establishes the necessity for the admission:

(b) An assessment regarding the inappropriateness of services at a less intensive level of care;

(c) A comprehensive **biopsychosocial** assessment and diagnostic formulation;

(d) A specific individualized treatment plan that integrates measurable goals/objectives and their required level of care **for** each of the patient's problems that are a focus of treatment;

(e) A specific plan for involvement of family members, unless therapeutically contraindicated; and

(f) A discharge plan, including an objective of referring the patient to further services, if needed, at less intensive levels of care within the **benefit** limit period.

(4) The request for preauthorization must be received **by** the reviewer designated by the Director, OCHAMPUS prior to the planned admission. In general, the decision regarding preauthorization shall **be** made within one business day of receipt of a request for preauthorization, and shall be followed with written confirmation. In the case of an authorization issued after an admission resulting from approval of a request **made** prior to the admission, the effective date of the certification shall be the date of the receipt of the request. However, if the request on which the approved authorization is based was made after the admission (and the case was not an emergency admission), the effective date of the authorization shall be the date of approval.

(5) Authorization prior to admission is not required in the case of a psychiatric emergency requiring an inpatient acute level of care, but authorization for a continuation of services must **be** obtained promptly. Admissions resulting from a bona fide psychiatric emergency should **be** reported within 24 hours **of** the admission or the next business day after the admission, but must be reported to

the Director, OCHAMPUS or a designee, within 72 hours of the admission. In the case of an emergency admission authorization resulting from approval of a request made within 72 hours of the admission, the effective date of the authorization shall be the date of the admission. However, if it is determined that the case was not a bona fide psychiatric emergency admission (but the admission can be authorized as medically or psychologically necessary), the effective date of the authorization shall be the date of the receipt of the request.

d. Concurrent review. Concurrent review of the necessity for continued stay will be conducted. The criteria for concurrent review shall be those set forth in paragraph B.6.a. of this chapter. In applying those criteria in the context of concurrent review, special emphasis is placed on evaluating the progress being made in the active clinical treatment being provided and on developing/refining appropriate discharge plans. In general, the decision regarding concurrent review shall be made within one business day of the review, and shall be followed with written confirmation.

7. Emergency inpatient hospital services. In the case of a medical emergency, benefits can be extended for medically necessary inpatient services and supplies provided to a beneficiary by a hospital, including hospitals that do not meet CHAMPUS standards or comply with the provisions of title VI of the Civil Rights Act (reference (z)), or satisfy other conditions herein set forth. In a medical emergency, medically necessary inpatient services and supplies are those that are necessary to prevent the death or serious impairment of the health of the patient, and that, because of the threat to the life or health of the patient, necessitate, the use of the most accessible hospital available and equipped to furnish such services. The availability of benefits depends upon the following three separate findings and continues only as long as the emergency exists, as determined by medical review. If the case qualified as an emergency at the time of admission to an unauthorized institutional provider and the emergency subsequently is determined no longer to exist, benefits will be extended up through the date of notice to the beneficiary and provider that CHAMPUS benefits no longer are payable in that hospital.

a. Existence of medical emergency. A determination that a medical emergency existed with regard to the patient's condition;

b. Immediate admission required. A determination that the condition causing the medical emergency required immediate admission to a hospital to provide the emergency care; and

c. Closest hospital utilized. A determination that diagnosis or treatment was received at the most accessible (closest) hospital available and equipped to furnish the medically necessary care.

8. RTC day limit.

a. With respect to mental health services provided on or after October 1, 1991, benefits for residential treatment are generally limited to 150 days in a fiscal year or 150 days in an admission (not including days of care prior to October 1, 1991). The RTC benefit limit is separate from the benefit limit for acute inpatient mental health care.

b. Waiver of the RTC day limit.

(1) There is a statutory presumption against the appropriateness of residential treatment services in excess of the 150 day limit. However, the Director, **OCHAMPUS**, (or designee) may in special cases, after considering the opinion of the peer review designated by the Director (involving a health professional who is not a federal **employee**) confirming that applicable criteria have been met, waive the RTC benefit limit in paragraph **B.8.a.** of this chapter **and** authorize payment for care beyond that limit.

(2) The criteria for waiver shall be those set forth in paragraph **B.4.g.** of this chapter. In applying those criteria to the context of waiver request reviews, special emphasis is placed on assuring that the record documents that:

(a) Active treatment. has taken place for the past 150 days and substantial progress has been made according to the plan of treatment.

(b) The progress made is insufficient, due to the complexity of the illness, for the patient to **be** discharged to a less intensive level of care.

(c) Specific evidence is presented to explain the factors which interfered with treatment progress during the 150 days of RTC care.

(d) The waiver request includes specific time frames and a specific plan of treatment which will lead to discharge.

(3) Where family or social issues complicate transfer to a lower level of intensity, the RTC is responsible for determining and arranging the supportive and adjunctive resources required to permit appropriate transfer. If the RTC fails adequately to meet this responsibility, the existence of such family or social issues shall be an inadequate basis for a waiver of the benefit limit.

(4) It is the responsibility of the patient's attending clinician to establish, through actual documentation from the medical record and other sources, that the conditions for waiver exist.

c. RTC day limits **do** not apply to services **provided** under the Program for the Handicapped (Chapter 5 of this Regulation) or services provided as partial hospitalization care.

9. Acute care day limits.

a. With respect. **to** mental **health** care services provided on or after October 1, 1991, payment for inpatient acute hospital care is, in general, statutorily limited as follows:

(1) **Adults**, aged 19 and over - 30 days in a fiscal year or 30 days in an admission (excluding days provided prior **to** October 1, 1991).

(z) Children and adolescents, **aged 18 and under** - 45 days in a **fiscal** year or 45 clays in an admission (excluding days provided prior to October 1, 1991).

b. It is the patient's age at the time of admission that determines the number **of** days available.

c. Waiver of the acute care day limits.

(1) There is a statutory presumption against the appropriateness of inpatient acute services in excess **of** the day limits set forth in paragraph **B.9.a.** of this chapter. However, the Director, **OCHAMPUS** (or designee) may in special cases, after considering the opinion of the peer review designated by the Director (**involving a health** professional who is not a federal employee) confirming that applicable criteria have been met, waive the acute inpatient limits described in paragraph B.9.a. of this chapter and authorize payment for care beyond those limits.

(2) The criteria for waiver of the acute inpatient limit shall be those set **forth** in paragraph **B.6.a.** of this chapter. In applying those criteria in the **context of** waiver request review, special emphasis is placed on determining **whether additional** days of acute inpatient mental health care are **medically/psychologically** necessary to complete necessary elements of the treatment plan **prior** to implementing appropriate discharge planning. A waiver may also be granted. **in** cases in which a patient exhibits well-documented new symptoms, **maladaptive** behavior, or medical complications which have appeared in the inpatient setting requiring a significant revision to the treatment plan.

(3) The clinician responsible for the patient's care is responsible for documenting that a waiver criterion has been met and must establish an estimated length of stay beyond the date of the inpatient limit. There must be evidence of a coherent and specific plan for assessment, intervention and reassessment that reasonably can be accomplished within the time frame of the additional days of **coverage requested** under the waiver provision.

(4) For patients in care at the time the inpatient limit is reached, a waiver must be requested prior to the limit. For patients being readmitted after having received 30 or 45 days in the fiscal year, the waiver review will be conducted at the time of the preadmission authorization.

d. Acute care day limits do not apply to services provided under the Program for the Handicapped (Chapter 5 of this Regulation) or services provided as partial hospitalization care.

10. Psychiatric partial hospitalization services.

a. In general. Partial hospitalization services are those services furnished by a CHAMPUS-authorized partial hospitalization program and authorized mental health providers for the active treatment of a mental disorder. **All** services must follow a medical model and vest patient care under the general direction **of** a licensed psychiatrist employed by the partial hospitalization center to ensure medication and physical needs of all the patients are considered. The primary or attending provider must be a CHAMPUS authorized mental health provider, operating within the scope of his/her license. These categories include physicians, clinical psychologists, certified psychiatric nurse specialists, clinical social workers,

marriage and family counselors, pastoral counselors and mental health counselors. Partial hospitalization services are covered as a basic program benefit only if they ~~are~~ are provided in accordance with this paragraph B.10. of this chapter.

b. Criteria for determining medical or psychological necessity of psychiatric partial hospitalization services. Psychiatric partial hospitalization services will be considered necessary only if all of the following **conditions** are present:

(1) The patient. is suffering significant. impairment from a mental disorder (as defined in Chapter 2) which interferes with age appropriate functioning.

(2) The patient is unable to maintain himself or herself in the community, with appropriate support, at a sufficient **level** of functioning to permit an adequate course of therapy exclusively on an outpatient basis (but is able, with appropriate support, to maintain a basic level of functioning to permit partial hospitalization services and presents no substantial imminent risk of harm to self or others).

(3) The patient is in need of crisis stabilization, treatment of partially stabilized mental health disorders, or services as a transition from an inpatient program.

(4) The admission into the partial hospitalization program is based on the development of an individualized diagnosis and treatment plan expected to **be** effective for that patient and permit treatment at a less intensive level.

c. Preauthorization and concurrent review requirements. All preadmission authorization and concurrent. review requirements and procedures applicable to acute mental health inpatient hospital care in paragraphs **A.12.** and B. of this chapter are applicable to the partial **hospitalization** program, except that the criteria for considering medical or psychological necessity shall be those set forth in paragraph **B.10.b.** of this chapter, and no emergency admissions will be recognized.

d. Institutional benefits limited to 60 days. Benefits for institutional services for partial hospitalization are limited to 60 treatment days (whether a full day or partial day program) in a fiscal year or **in** an admission. This limit may be extended by waiver.

e. Waiver of the 60-day partial hospitalization program limit. The Director, **OCHAMPUS** (or designee) may, in special cases, waive the 60-day partial hospitalization benefit and authorize payment for care beyond the 60-day limit.

(1) **The** criteria for waiver are set forth in paragraph **B.10.b.** of this chapter. In applying these criteria in the context of waiver request review, special emphasis is placed on determining whether additional days of partial hospitalization are medically/psychologically necessary to complete essential elements of the treatment plan **prior** to discharge. Consideration is also given in cases in which a patient exhibits well-documented new symptoms or **maladaptive** behaviors which have appeared in the partial hospitalization "setting requiring significant revisions to the treatment plan.



(2). The clinician responsible for the patient's care is responsible for documenting the need for additional days and must establish an estimated length of stay beyond the date of the 60-day limit. There must be evidence of a coherent and specific plan for assessment, intervention and reassessment that reasonably can be accomplished within the time frame of the additional days of coverage requested under the waiver provisions.

(3) For patients in care at the time the partial hospitalization program limit is reached, a waiver must be requested prior to the limit. For patients being readmitted after having received 60 days in the fiscal year, the waiver review will be conducted at the time of the preadmission authorization.

f. Services and supplies. The following services and supplies are included in the per diem rate approved for an authorized partial hospitalization program:

(1) Board. Includes use of the partial hospital facilities such as food service, supervised therapeutically constructed recreational and social activities, and other general services as considered appropriate by the Director, **OCHAMPUS**, or a designee.

(2) Patient assessment. Includes the assessment of each individual accepted by the facility, and must, at a minimum, consist of a physical examination; psychiatric examination; psychological assessment; assessment of physiological, biological and cognitive processes; developmental assessment; **family** history and assessment; social history and assessment; educational or vocational history and assessment; environmental assessment; and recreational/activities assessment. Assessments conducted within 30 days prior to admission to a partial program may be used if approved and deemed adequate to permit treatment planning by the partial hospital program.

(3) Psychological testing.

(4) Treatment services. All services, supplies, equipment and space necessary to fulfill the requirements of each patient's individualized diagnosis and treatment plan (with the exception of the five psychotherapy sessions per week which may be allowed separately for individual or family psychotherapy based upon the provisions of **B.10.g.** of this chapter.) All mental health services must be provided by a CHAMPUS authorized individual professional provider of mental health services. [Exception: PHPs that employ individuals with master's or doctoral level degrees in a mental health discipline who do not meet the **licensure**, certification and experience requirements for a qualified mental health provider but are actively working toward **licensure** or certification, may provide services within the all-inclusive per diem rate but the individual must work under the clinical supervision of a fully qualified mental health provider employed by the PHP.]

g. Social services required. The facility must **provide** an active social services component which assures the patient appropriate living arrangements after treatment **hours**, transportation to and from the facility, arrangement of community based support services, referral of suspected child abuse to the appropriate state agencies, and effective after care arrangements, at a minimum.

h. Educational services required. Programs treating children and adolescents must ensure the provision of a state certified educational component which assures that patients **do** not fall behind in educational placement while receiving partial hospital treatment. CHAMPUS **will** not fund the cost of educational services separately from the per diem rate. The hours devoted to education do not count toward the therapeutic **half** or full day program.

i. Family therapy required. The facility must ensure the provision of an active. family therapy treatment component which assures that each patient and family. participate at least weekly in family therapy provided by the institution and rendered by a CHAMPUS authorized individual professional provider of mental health services. There is no acceptable substitute for family therapy. An exception to this requirement may **be** granted on a case-by-case basis by the Director, **OCHAMPUS**, or designee, only if family therapy is clinically contraindicated.

j. Professional mental health benefits limited. Professional mental health benefits are limited to a maximum of one session (60 minutes individual, 90 minutes family) per authorized treatment day not to exceed five sessions in any calendar week. These may be billed separately from the partial hospitalization per diem rate only when rendered by an attending, CHAMPUS-authorized mental health professional who is not an employee of, or under contract with, the partial hospitalization program for purposes of providing clinical patient care.

k. Non-mental health related medical services. Separate billing will be allowed for otherwise covered, non-mental health related medical services.

**C. PROFESSIONAL SERVICES BENEFIT.**

1. General. Benefits may be extended for those covered services described in this section C., that are provided in accordance with good medical practice and established standards of quality by physicians or other authorized individual professional providers, as set forth in Chapter 6 of this Regulation. Such benefits are subject to all applicable definitions, conditions, exceptions, limitations, or exclusion as may be otherwise set forth in this or other chapters of this Regulation. Except as otherwise specifically authorized, to be considered for benefits under this section C., the described services must be rendered by a physician, or prescribed, ordered, and referred medically by a physician to other authorized individual professional providers. Further, except under specifically defined circumstances, there should be an attending physician in any episode of care. (For example, certain services of a clinical psychologist are exempt from this requirement. For these exceptions, refer to Chapter 6.)

a. Billing practices. To be considered for benefits under this section C., covered professional services must be performed personally by the physician or other authorized individual professional provider, who is other than a salaried or contractual staff member of a hospital or other authorized inst.itution, and who ordinarily and customarily bills on a **fee-**for-service basis for professional services rendered. Such billings must. be itemized fully and sufficiently descriptive to permit CHAMPUS to determine

whether benefits are authorized by this Regulation. See paragraph C.3.m. of this Chapter for the requirements regarding the special circumstances for teaching physicians. For continuing professional care, claims should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 **days** either by the beneficiary or sponsor, or directly by the physician or other authorized individual professional provider on behalf of a beneficiary (refer to Chapter 7 of this Regulation).

b. Services must be related. Covered professional services must be rendered in connection with and directly related to a covered diagnosis or definitive set of symptoms requiring medically necessary treatment.

2. Covered services of physicians and other authorized individual professional providers

a. Surgery. Surgery means operative procedures, including related preoperative and postoperative care; reduction of fractures and dislocations; injection and needling procedures of the joints; laser surgery of the **eye**; and the following procedures:

**Bronchoscopy**

**Laryngoscopy**

Thoracoscopy

Catheterization of the heart

Arteriograph thoracic lumbar

Esophagoscopy

**Gastrosocopy**

Proctoscopy

**Sigmoidoscopy**

Peritoneoscopy

Cystoscopy

**Colonoscopy**

Upper G.I. panendoscopy

Encephalograph

**Myelography**

Discography

Visualization of intracranial aneurysm by **intracarotid**  
injection of dye, with exposure of carotid artery,  
unilateral

**Ventriculography**

**Insufflation** of uterus and fallopian tubes for determination  
of tubal patency (Rubin's test of injection of  
radiopaque medium or for dilation)

Introduction of opaque media into the cranial arterial  
system, preliminary to cerebral **arteriography**, or into  
vertebral and **subclavian** systems

Intraspinal introduction of air preliminary to  
**pneumoencephalography**

Intraspinal introduction of opaque media preliminary to  
**myelography**

Intraventricular introduction of air preliminary to  
**ventriculography**

NOTE : The Director, OCHAMPUS, or a designee, shall determine such additional procedures that. may **fall** within the intent of this definition of "surgery."

- b. Surgical assistance.
- c. Inpatient medical services.
- d. Outpatient medical services.
- e. Psychiatric services.
- f. Consultation services.
- g. Anesthesia services.
- h. Radiation therapy services.
- i. X-ray services.
- j. Laboratory and pathological services.
- k. Physical medicine services or physiatry services.
- l. Maternity care.
- m. Well-baby care.

n. Other medical care. **Other** medical care includes, but is not limited to, **hemodialysis**, inhalation therapy, shock therapy, and chemotherapy. The Director, **OCHAMPUS**, or a designee, shall determine those additional medical services for which benefits may be extended under this paragraph.

NOTE : A separate professional charge for the oral administration of approved **antineoplastic** drugs is not covered.

- o. Private duty (special) nursing **services**.

p. Routine eye examinations. Coverage for routine eye examinations is limited to dependents of active duty members, to one examination per calendar year per person, and to services rendered on or after October 1, 1984.

### 3. Extent of professional benefits

a. Multiple **surgery**. In cases of multiple surgical procedures performed during the same operative session, benefits shall be extended as follows:

(1) One hundred (100) percent of the **CHAMPUS-determined** allowable charge for the major surgical procedure (the procedure for which the greatest amount is payable under the applicable reimbursement method); and

(2) Fifty (50) percent of the CHAMPUS-determined allowable charge for each of the other surgical procedures.

(3) Except that:

(a) If the multiple surgical procedures involve the fingers or toes, benefits for the first surgical procedure shall be at one hundred (100) percent of the **CHAMPUS-determined** allowable charge; the second procedure at fifty (50) percent; and the third and subsequent procedures at twenty-five (25) percent.

(b) If the multiple surgical procedures include an incidental procedure, no benefits shall be allowed for the incidental procedure.

(c) If the multiple surgical procedures involve specific procedures identified by the Director, **CHAMPUS**, benefits shall be limited as set forth in CHAMPUS instructions.

b. Different types of inpatient care, concurrent. If a beneficiary receives inpatient medical care during the same admission in which he or she also receives surgical care or maternity care, the beneficiary shall be entitled to the greater of the CHAMPUS-determined allowable charge for either the inpatient medical care or surgical or maternity care received, as the case may be, but not both; except that the provisions of this paragraph **C.3.b.** shall not apply if such inpatient medical care is for a diagnosed condition requiring inpatient medical care not related to the condition for which surgical care or maternity care is received, and is received from a physician other than the one rendering the surgical care or maternity care.

NOTE : This provision is not meant to imply that when extra time and special effort are required due to **postsurgical** or postdelivery complications, the attending physician may not request **special** consideration for a higher than usual charge.

c. Need for surgical assistance. Surgical assistance is payable only when the complexity of the procedure warrants a surgical assistant (other than the surgical nurse or other such operating room personnel), subject to utilization review. In order for benefits **to be** extended for surgical assistance service, the primary surgeon may be required to certify in writing to the **nonavailability** of a qualified intern, resident, or other house physician. When a claim is received for a surgical assistant involving the following circumstances, special review is required to ascertain whether the surgical assistance service meets the medical necessity and other requirements of this section C.

(1) If the surgical assistance occurred in a hospital that has a residency program in a specialty appropriate to the surgery;

(2) If the surgery was performed by a team of surgeons;

(3) If there were multiple surgical assistants; or

(4) If the surgical assistant **was** a partner of or from the same group of practicing surgeons as the attending surgeon.

d. Aftercare following surgery. Except for those diagnostic **procedures** classified as surgery **in** this-section C., and injection and needling procedures involving the joints, the benefit payments made for surgery (regardless of the setting in which it is rendered) include normal aftercare, whether the aftercare is billed for by the physician or other authorized individual professional provider **on** a global, all-inclusive basis, or billed for separately.

e. Cast and **sutures, removal.** The benefit payments made for the application of a cast or of sutures normally covers the postoperative care including the removal **of** the cast or sutures. When the application is made in one geographical location and the removal of the cast or sutures must be done in another geographical location, a separate benefit payment may be provided for the removal. The intent of this provision is to provide a separate benefit only when it is impracticable for the beneficiary to use the services of the provider that applied the cast originally. Benefits are not available for the services of a second provider if those services reasonably could have been rendered by the individual professional provider who applied the cast or sutures initially.

f. Inpatient care, concurrent. Concurrent inpatient care by more than one **individual professional** provider is covered if required because of the severity and complexity of the beneficiary's condition or because the beneficiary has multiple conditions that require treatment by providers of different specialties. Any claim for concurrent care must be reviewed **before** extending benefits in order to ascertain the condition of the beneficiary at the time the concurrent care was rendered. In the absence of such determination, benefits are payable only for inpatient care rendered by one attending physician or other authorized individual professional provider.

g. Consultants who become the attending **surgeon.** A consultation performed within 3 days of surgery **by** the attending physician is considered a preoperative examination. Preoperative examinations are an integral part of the surgery and a separate benefit is not payable for the consultation. If more than 3 days elapse between the consultation and surgery (performed by the same physician), benefits may be extended for the consultation, subject to review.

h. Anesthesia administered by the attending physician. A separate benefit is not payable for anesthesia administered by the attending physician (surgeon or obstetrician) or dentist, or by the surgical, obstetrical, or dental assistant.

i. Treatment of ~~mental disorders.~~ CHAMPUS benefits for **the** treatment of mental disorders are payable for beneficiaries who are outpatients or inpatients of **CHAMPUS-authorized** general or psychiatric hospitals, RTCS, or specialized treatment facilities, **as** authorized by the Director, **OCHAMPUS**, or a designee. All such

services are subject to review for medical or psychological necessity and for quality of care. The Director, **OCHAMPUS**, reserves the right to require **preauthorization** of mental health services. Preauthorization may be conducted by the Director, **OCHAMPUS**, or a designee. In order to qualify for CHAMPUS mental health benefits, the patient must be diagnosed by a CHAMPUS-authorized licensed, qualified mental health professional to **be** suffering from a mental disorder, according to the criteria listed in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Benefits are limited for certain mental disorders, such as specific developmental disorders. No benefits are payable **for** "Conditions Not Attributable to a Mental Disorder, " or **V** codes. In order for treatment **of** a mental disorder to be medically or psychologically necessary, the patient must, as a result of a diagnosed mental disorder, **be** experiencing both physical **or** psychological distress and an impairment in his or her ability to function in appropriate occupational, educational or social roles. It is generally the degree to which the patient's ability to function' is impaired that determines the **level** of care (if any) required to treat the patient's condition.

(1) Covered diagnostic and therapeutic services. Subject to the requirements and limitations stated, CHAMPUS benefits are payable for the following services when rendered in the diagnosis or treatment of a covered mental disorder by a **CHAMPUS-authorized**, qualified mental health provider practicing within the scope of his or her license. Qualified mental health providers are: psychiatrists or other physicians; clinical psychologists, certified psychiatric nurse specialists or clinical social workers; and certified marriage and family therapists, pastoral, and mental health counselors, under a physician's supervision. No payment will be made for any service listed in this subparagraph **C.3.i. (1)** rendered by an individual who does not meet the criteria of Chapter 6 of this Regulation for his or her respective profession, regardless of whether the provider is an independent professional provider or an employee of an authorized professional or institutional provider.

(a) Individual psychotherapy, adult or child. A covered individual psychotherapy session is no more than 60 minutes in length. An individual psychotherapy session of up to 120 minutes in length is payable for crisis intervention.

(b) Group psychotherapy. A covered group psychotherapy session is no more than 90 minutes in length.

(c) Family or conjoint psychotherapy. A covered family or conjoint psychotherapy **session** is no more than 90 m-inutes in length. A family or conjoint psychotherapy session of up to 180 minutes in length is payable for crisis intervention.

(d) Psychoanalysis. Psychoanalysis is covered when provided by a graduate or candidate **of** a psychoanalytic training institution recognized by the American Psychological Association or the American Psychiatric Association and when preauthorized by the Director, OCHAMPUS, or a designee.

(e) Psychological testing and assessment. Psychological testing and assessment is generally limited to six hours of testing in a fiscal year when medically or psychologically necessary and in conjunction with otherwise covered psychotherapy. Testing or assessment in excess of these limits requires review for medical necessity. Benefits will not be provided for the Reitan-Indiana battery when administered to a patient under age five, for self-administered tests administered to patients under age 13, or for psychological testing and assessment as part of an assessment for academic placement.

(f) Administration of psychotropic drugs. When prescribed by an authorized provider qualified by licensure to prescribe drugs.

(g) Electroconvulsive treatment. When provided in accordance with guidelines issued by the Director, OCHAMPUS.

(h) Collateral visits. Covered collateral visits are those that are medically or psychologically necessary for the treatment of the patient and, as such, are considered as a psychotherapy session for purposes of subparagraph C.3.i. (2) of this chapter.

(2) Limitations and review requirements

(a) Outpatient psychotherapy. Outpatient psychotherapy generally is limited to a maximum of two psychotherapy sessions per week, in any combination of individual, family, conjoint, collateral, or group sessions. Before benefits can be extended for more than two outpatient psychotherapy sessions per week, professional review of the medical or psychological necessity for and appropriateness of the more intensive therapy is required.

(b) Inpatient psychotherapy. Coverage of inpatient psychotherapy is based on the medical or psychological necessity for the services identified in the patient's treatment plan. As a general rule, up to five psychotherapy sessions per week are considered appropriate. Additional sessions per week or more than one type of psychotherapy session performed on the same day (for example, an individual psychotherapy session and a family psychotherapy session on the same day) could be considered for coverage, depending on the medical or psychological necessity for the services. Benefits for inpatient psychotherapy will end automatically when authorization has been granted for the maximum number of inpatient mental health days in accordance with the limits as described in this Chapter 4, unless additional coverage is granted by the Director, OCHAMPUS or a designee.

(3) Covered ancillary therapies. Includes art, music, dance, occupational, and other ancillary therapies, when included by the attending provider in an approved inpatient, residential treatment plan and under the clinical supervision of a licensed doctoral level mental health professional. These ancillary therapies are not separately reimbursed professional services but are included within the institutional reimbursement.

(4) Review of claims for treatment of mental disorder. The Director, OCHAMPUS, shall establish and maintain procedures for review, including professional review, of the services provided for the treatment of mental disorders.



j. Physical and occupational therapy

(1) Physical therapy. To be covered, physical therapy must be related to a covered medical condition. If performed by other than a physician, a physician (or other authorized individual professional provider acting within the scope of their license) shall refer the patient for treatment and supervise the physical therapy. Generally, coverage of outpatient physical therapy is limited to a 60-day period, at up to two physical therapy sessions per week. Physical therapy beyond this length or frequency requires documentation of the medical necessity for the therapy and the anticipated results of the therapy. General exercise programs are not covered, even if recommended by a physician and conducted by qualified personnel. Passive exercises and range of motion exercises are not covered except when prescribed as an integral part of a comprehensive program of physical therapy.

( 2 ) Occupational therapy. To be covered, occupational therapy must be related to a covered medical condition and must be directed to assisting the patient to overcome or compensate for disability resulting from illness, injury, or the effects of treatment of a covered condition. If performed by other than a **physician, a physician shall** prescribe the treatment and a physician **shall** supervise the occupational therapy. The occupational therapist providing the therapy shall be an employee of a **CHAMPUS-authorized** institutional provider and the services must be rendered in connection with CHAMPUS authorized care. Only those occupational therapy services that are rendered as part of an organized inpatient or outpatient rehabilitation program are covered. Occupational therapists are not considered CHAMPUS-authorized providers in their own right and may not submit bills on a fee-for-service basis. The employing institutional provider shall bill for the services of the occupational therapist.

k. Well-baby care. Benefits routinely are payable for well-baby care from birth up to the child's second birthday.

(1) The following services are payable when rendered as a part of a specific well-baby care program and when rendered by the attending pediatrician, family physician, or a pediatric nurse practitioner:

- (a) Newborn examination, PKU tests, and newborn circumcision.
- (b) History, physical examination, discussion, and counseling.
- (c) Vision, hearing, and dental screening.
- (d) Developmental appraisal.
- (e) Immunization (that is, DPT, polio, measles, mumps, and rubella) .
- (f) Tuberculin test, hematocrit or **Hgb.**, and urinalysis.

(2) Additional services or visits required because of specific findings or because of the particular circumstance of the individual case are covered if medically necessary and otherwise authorized for benefits under CHAMPUS .

1. Private duty (special) nursing. Benefits are available for the skilled nursing services rendered by a private duty (special) nurse to a beneficiary **requiring** intensive skilled nursing care that can only be provided with the technical proficiency and scientific skills of an R.N. The specific skilled nursing services being rendered are controlling, not the condition of the patient **or** the professional status **of** the private duty (special) nurse rendering the services.

(1.) Inpatient private duty (special) nursing services are limited to those rendered to an inpatient in a hospital that does not have an ICU. In addition, under specified circumstances, private duty (special) nursing in the **home** setting also is covered.

(2) The private duty (special) nursing care must be ordered and certified to be medically necessary by the attending physician.

(3) The skilled nursing care must be rendered by a private duty (special) nurse who is neither a member of the immediate family nor is a member of the beneficiary's household.

(4) Private duty (special) nursing care does not, except incidentally, include providing services that provide or support primarily the essentials of daily living **or** acting as a companion or sitter.

(5) If the private duty (special) nursing care services being performed are primarily those that could **be** rendered by the average adult with minimal instruction or supervision, the services would not qualify as covered private duty (special) nursing services, regardless of whether performed by an R.N., regardless of whether or not ordered and certified to by the attending physician, and regardless of the condition of the patient.

(6) In order for such services to be considered for benefits, a private duty (special) nurse is required **to** maintain detailed daily nursing notes, whether the case involves inpatient nursing service or nursing services rendered in the home setting.

(7) Claims for continuing private duty (special) nursing care shall be submitted at least every 30 days. Each claim will be reviewed and the nursing care evaluated whether it continues to **be** appropriate and eligible for benefits.

(8) In most situations involving private duty (special) nursing care rendered in the home setting, benefits will be available only for a portion of the care, that is, providing benefits only for that time actually required to perform medically necessary skilled nursing services. If full-time private duty (special) nursing services are engaged, usually for convenience or to provide personal services to the patient, CHAMPUS benefits are payable only for that portion of the day during which skilled nursing services are rendered, but in no event is less than 1 hour of nursing care payable in any 24-hour period during which skilled nursing services are determined to have been rendered. Such situations often are

better accommodated through the use of visiting nurses. This allows the personal services that are not **coverable by** CHAMPUS to be obtained at lesser cost from other than an R.N. Skilled nursing services provided by visiting nurses are covered under CHAMPUS.

NOTE : When the services of an R.N. are not available, benefits may be extended for the otherwise covered services of a **L.P.N.** or **L.V.N.**

m. Physicians in a teaching setting.

(1) Teaching Physicians.

(a) General. The services of teaching physicians may be reimbursed on an allowable charge basis only when the teaching physician has established an attending physician relationship between the teaching physician and the services (e.g., services rendered as a consultant, assistant **surgeon, etc.**). Attending physician services may include both direct patient care services or direct supervision of care provided by a physician in training. In order to be considered an attending physician, the teaching physician must:

1 Review the patient's history and the record of examinations and tests in the institution, and make frequent reviews of the patient's progress; and

2 Personally examine the patient; and

3 Confirm or revise the diagnosis and determine the course of treatment to be followed; and

4 Either perform the physician's services required by the patient or supervise the treatment so as to assure that appropriate services are provided by physicians in training and that the care meets a proper quality level; and

5 Be present and ready to perform any service performed by an attending physician in a **nonteaching** setting when a major surgical procedure or a complex or dangerous medical procedure is performed; and

6 Be personally responsible for the patient's care, at least throughout the **period** of hospitalization.

(b) Direct supervision by an attending physician of care provided by physicians in training. Payment on the basis of allowable charges may be made for the professional services rendered to a beneficiary by his/her attending physician when the attending physician provides personal and identifiable direction to physicians in training who are participating in the care of the patient. It is not necessary that the attending physician be personally present for all services, but the attending physician must be on the provider's premises and available to provide immediate personal assistance and direction if needed.

(c) Individual, personal services. A teaching physician may be reimbursed on an **allowable** charge basis for any individual, identifiable service rendered to a CHAMPUS beneficiary, so long as the service is a covered service and is normally reimbursed separately, and so long as the patient records substantiate the service.

(d) Who may bill. The services of a teaching physician must be **billed** by the institutional provider when the physicians employed **by** the provider or a related entity or under a contract which provides for payment **to** the physician **by** the provider or a related entity. Where the teaching physician has no relationship with the provider (except for standard physician privileges to admit patients) and generally treats patients on a fee-for-service basis in the private sector, the teaching physician may submit claims under his/her own provider number.

(2) Physicians in training. Physicians in training in an approved teaching program are considered to be "students" and may not be reimbursed directly by CHAMPUS for services rendered to a beneficiary when their services are provided as part of their employment (either salaried or contractual) by a hospital or other institutional provider. Services of physicians in training may **be** reimbursed on an allowable charge basis only if:

(a) The physician in training is fully licensed to practice medicine by the state in which the services are performed, and

(b) The services are rendered outside the scope and requirements of the approved training program to which the physician in training is assigned.

#### D. OTHER BENEFITS

1. General. **Benefits** may be extended for the allowable charge **of** those other covered services and supplies described in this section D., which are provided in accordance with good medical practice and established standards of quality by those other authorized providers described in Chapter 6 of this Regulation. Such benefits are subject to all applicable definitions, conditions, limitations, or exclusions as otherwise may be set forth in this or other chapters of this Regulation. To be considered for benefits under this section D., the described services or supplies must be prescribed and ordered by a physician. Other authorized individual professional providers acting within their scope of licensure may also prescribe and order these services and supplies unless otherwise specified in this section D. For example, durable medical equipment and **cardiorespiratory** monitors can only be ordered by a physician.

2. Billing practices. To **be** considered for benefits under this Section D., covered services and supplies must be provided and billed for by an authorized provider as set forth in Chapter 6 of this Regulation. Such billing must be itemized fully and described sufficiently, even when CHAMPUS payment is determined under the CHAMPUS **DRG-based** payment system, so that CHAMPUS can determine whether benefits are authorized **by** this Regulation. Except for claims subject to the

CHAMPUS **DRG-based** payment system, whenever continuing charges are involved, claims should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days (monthly) either by the beneficiary **or** sponsor or directly **by** the provider. For claims subject to the CHAMPUS **DRG-based** payment system, claims may be submitted only after the **beneficiary has** been discharged or transferred from the hospital.

3. Other covered services and supplies

a. Blood. If whole blood or plasma (or its derivatives) are provided and billed for by an authorized institution in connection with covered treatment, benefits are extended as set forth in section B. of this chapter. If blood is billed for directly to a beneficiary, benefits may **be** extended under this section D. in the same manner as a medical supply.

b. Durable medical equipment

(1) Scope of benefit. Subject to the exceptions in paragraphs (2) and (3) below, only durable medical equipment (**DME**) which is ordered by a physician for the specific use of the beneficiary, and which complies with the definition of "Durable Medical Equipment" in Chapter 2 of this Regulation, and which is **not** otherwise excluded **by** this Regulation qualifies as a Basic Program benefit.

(2) Cardiorespiratory monitor exception.

(a) **When** prescribed by a physician who is otherwise eligible as a CHAMPUS individual professional provider, or who is on active duty with a United States Uniformed Service, an electronic cardiorespiratory monitor, including technical support necessary for the proper use of the monitor, may be cost-shared as durable medical equipment when supervised by the prescribing physician for in-home use by:

1 An infant beneficiary who has had an apparent life-threatening event, as defined in guidelines issued **by** the Director, **OCHAMPUS**, or a designee, or,

2 An infant beneficiary who is a subsequent or multiple birth biological sibling of a victim of sudden infant death syndrome (**SIDS**), or,

3 An infant beneficiary whose birth weight was 1,500 grams or less, or,

4 An infant beneficiary who is a **pre-term** infant. with pathologic apnea, as defined in guidelines issued by the Director, **OCHAMPUS**, or a designee, or,

5 Any beneficiary who has a condition or suspected condition designated in guidelines issued **by** the Director, **OCHAMPUS**, or **designee, for which** the in-home use of the **cardiorespiratory** monitor otherwise meets Basic Program requirements.

(b) The following types of services and items may be cost-shared when provided in conjunction with **an** otherwise authorized **cardiorespiratory** monitor:

1 Trend-event recorder, including technical support necessary for the proper use of the recorder.

2 Analysis of recorded physiological data associated with monitor alarms.

3 Professional visits for services otherwise authorized by this Regulation, and for family training **on** how to respond to an apparent life-threatening event.

4 Diagnostic testing otherwise authorized by this Regulation.

(3) Basic mobility equipment exception. A wheelchair, or a CHAMPUS-approved alternative, which is medically necessary to provide basic mobility, including reasonable additional cost for medically necessary modifications to accommodate a particular disability, may be cost-shared as durable medical equipment. . . .

( 4 ) Exclusions. DME which is otherwise qualified as a benefit is excluded as a benefit under the following circumstances:

(a) DME for a beneficiary who is a patient in a type of facility that ordinarily provides the same type of DME item **to** its patients at no additional charge in the usual course of providing its services.

(b) DME which is available to the beneficiary from a Uniformed Services Medical Treatment Facility.

(c) **DME** with deluxe, luxury, or immaterial features which increase the **cost** of the item to the government relative to similar item without those features.

(5) Basis for reimbursement. The cost of DME may be shared by the CHAMPUS based upon the **price which** is most advantageous to the government taking into consideration the anticipated duration of the medically necessary need **for** the equipment and current price information **for** the type of item. The cost analysis must include a comparison of the total price of the item as a monthly rental charge, a lease-purchase price, and a lump-sum purchase price and a provision for the time value of **money** at the rate determined by the U.S. Department of the Treasury.

c. Medical supplies and dressings (consumables). Medical supplies and dressings (consumables) are those that do not withstand prolonged, repeated use. Such items must **be** related directly to an appropriate and verified covered medical condition of the specific beneficiary for whom the item was purchased and obtained from a medical supply company, a pharmacy, or authorized institutional provider. Examples of covered medical supplies and dressings are disposable syringes for a known diabetic, colostomy sets, irrigation sets, and elastic bandages. An external surgical garment specifically designed for use following a mastectomy is considered a medical supply item.

NOTE : Generally, the allowable charge of a medical supply item will be under \$100. Any item over this amount must be reviewed to determine whether it would not qualify as a DME item. If it is, in fact, a medical supply item **and** does not represent an excessive charge, it can **be** considered for benefits under paragraph **D.3.c.**, above.

d. Oxygen. Oxygen and equipment for its administration are covered. Benefits are **limited** to providing a tank unit at one location with oxygen limited to a 30-day supply at any one time. Repair and adjustment of **CHAMPUS-purchased** oxygen equipment also is covered.

e. Ambulance. Civilian ambulance service to, from, and between hospitals is covered when medically necessary in connection with otherwise covered services and supplies and a covered medical condition. Ambulance service also is covered for transfers to a Uniformed Service Medical Treatment Facility (**USMTF**). For the purpose of CHAMPUS payment, ambulance service is an outpatient service (including in connection with maternity care) with the exception of otherwise covered transfers between hospitals which are cost-shared on an inpatient basis. Ambulance transfers from a hospital based emergency room to another hospital more capable of providing the required care will also be cost-shared on an inpatient basis.

NOTE : The inpatient cost-sharing provisions for ambulance transfers only apply to otherwise covered transfers between hospitals; i.e., acute care, general, and special hospitals; psychiatric hospitals; and long-term hospitals.

(1) Ambulance service is covered for emergency transfers from a beneficiary's place of residence, accident scene, or other location to a USMTF, and for transfer to a USMTF after treatment at, or admission to, a civilian hospital, if ordered by other than a representative of the USMTF.

(2) Ambulance service cannot be used instead of taxi service and is not payable when the patient's condition would have permitted use of regular private transportation; **nor** is it payable when transport or transfer of a patient is primarily for the purpose of having the patient nearer to home, family, friends, or personal physician. Except as described in subparagraph **D.3.e.(1)**, above, transport must be to closest appropriate facility by the least costly means.

(3) Vehicles such as **medicabs** or **ambicabs** function primarily as public passenger conveyances transporting patients to and from their medical **appointments**. No actual medical care is provided to the patients in transit. These types of vehicles do not qualify for benefits for the purpose of CHAMPUS payment.

(4) Ambulance services by other than land vehicles (such as a boat or airplane) may be considered only when the pickup point is inaccessible by a land vehicle, or when great distance or other obstacles are involved in transporting the patient to the nearest hospital with appropriate facilities and the patient's medical condition warrants speedy admission or is such that transfer by other means is contraindicated.

**f. Prescription drugs and medicines.** Prescription drugs and medicines that by United States law require a physician's or other authorized individual professional provider's prescription (acting within the scope "of their license") and that are ordered or prescribed by a **physician** or other authorized individual professional provider (except that insulin is covered for a known diabetic, even though a prescription may not be required for its purchase) in connection with an **otherwise** covered condition or treatment, including Rh immune globulin.

(1) Drugs administered by a physician or other authorized individual professional provider as an integral part of a procedure covered under sections B. or C. of this chapter (such as chemotherapy) are not covered under this subparagraph inasmuch as the benefit for the institutional services or the professional services in connection with the procedure itself also includes the drug used.

(2) CHAMPUS benefits may not be extended for drugs not approved by the U.S. Food and Drug Administration for commercial marketing. Drugs grandfathered by the Federal Food, Drug and Cosmetic Act of 1938 may be covered under CHAMPUS as if FDA approved.

**g. Prosthetic devices.** The purchase of prosthetic devices is limited to artificial limbs and eyes, except those items that are inserted surgically into the body as an essential and integral part of an otherwise covered surgical procedure are not excluded.

NOTE : In order for CHAMPUS benefits to be extended, any surgical implant must be approved for use in humans by the U.S. Food and Drug Administration. Devices that are approved only for investigational use in humans are not payable.

**h. Orthopedic braces and appliances.** The purchase of leg braces (including attached shoes), arm braces, back braces, and neck braces is covered. Orthopedic shoes, arch supports, shoe inserts, and other supportive devices for the feet, including special-ordered, custom-made built-up shoes or regular shoes subsequently built up, are not covered.



E. SPECIAL BENEFIT INFORMATION

1. General. There are certain circumstances, conditions, or limitations that impact the extension of benefits and that require special emphasis and explanation. This section E. sets forth those benefits and limitations recognized to be in this category. The benefits and limitations herein described also are subject to all applicable definitions, conditions, limitations, exceptions, and exclusions as set forth in this or other chapters of this Regulation, except as otherwise may be provided specifically in this section E.

2. Abortion. The statute under which CHAMPUS operates prohibits payment **for** abortions with one single exception--where the life of the woman would **be** endangered **if** the fetus were carried to term. Covered abortion services are limited to medical services and supplies only. Physician certification is required attesting that the abortion was performed because the mother's life would have been endangered if the fetus were carried to term. Abortions performed for suspected or confirmed fetal abnormality (e.g., **anencephalic**) or for mental health reasons (e.g., threatened suicide) do not fall within the exceptions permitted within the language of the statute and are not authorized for payment under CHAMPUS.

NOTE : Covered abortion services are limited to medical services or supplies only for the single circumstance outlined above and do not include abortion counseling or referral fees. Payment is not allowed for any services involving preparation for, or normal **followup** to, a noncovered abortion. The Director, **OCHAMPUS**, or a designee, shall issue guidelines describing the policy on abortion.

3. Family planning. The scope of the CHAMPUS family planning benefit is as follows:

a. Birth control (such as contraception)

(1) Benefits provided. Benefits are available for services and supplies related to preventing conception, including the following:

(a) Surgical insertion, removal, or replacement of intrauterine devices.

(b) Measurement for, and purchase of, contraceptive diaphragms (and later remeasurement and replacement).

(c) Prescription oral contraceptives.

(d) Surgical sterilization (either male or female).

(2) Exclusions. The family planning benefit does not include the following:

(a) Prophylactics (condoms).

(b) **Spermicidal** foams, jellies, and sprays not requiring a prescription.

(c) Services and supplies related **to noncoital** reproductive technologies, including but not limited to artificial insemination (including any costs related to **donors** or semen banks), in-vitro fertilization and gamete **intrafallopian** transfer.

(d) Reversal of a surgical sterilization procedure (male or female).

1). Genetic testing. Genetic testing essentially is preventive rather than related to active medical treatment of an illness or injury. However, under the family planning benefit, genetic testing **is** covered when performed in certain high risk situations. For the purpose of CHAMPUS, genetic testing includes tests to detect developmental abnormalities as well as purely genetic defects.

(1) Benefits provided. Benefits may be extended for genetic testing performed **on** a pregnant beneficiary under the following prescribed circumstances. The tests must **be** appropriate to the specific risk situation and must meet one of the following criteria:

(a) The mother-to-be is 35 years **old** or older; or

(b) The **mother-** or father-to-be has had a previous child born with a congenital abnormality; or

(c) Either the **mother-** or father-to-be has a family history of congenital abnormalities; or

(d) The mother-to-be contracted rubella during the first trimester of the pregnancy; or

(e)' Such other specific situations as may be determined by the Director, **OCHAMPUS**, or a designee, to **fall** within the intent of this paragraph **E.3.b.**

(2) Exclusions. It is emphasized that routine or demand genetic testing is not covered. Further, genetic testing does not include the following:

(a) Tests performed to establish paternity of a child.

(b) Tests **to** determine the sex of an unborn child.

4. Treatment of substance use disorders. Emergency and inpatient hospital care for complications of alcohol and drug abuse or dependency and detoxification are covered as for any other medical condition. Specific coverage for the treatment of substance use disorders includes detoxification, rehabilitation, and outpatient care provided in authorized substance use disorder rehabilitation facilities.

a. Emergency and inpatient hospital services. Emergency **and** inpatient hospital services are covered when medically necessary for the active medical treatment of the acute phases of substance abuse withdrawal (detoxification), for stabilization, and for treatment of medical complications of substance use disorders. Emergency and inpatient hospital services are considered medically necessary only when the patient's condition is such that the personnel and facilities **of** a hospital are required. Stays provided for substance use disorder rehabilitation in a hospital-based rehabilitation facility are covered, subject to the provisions of paragraph E.4.b. of this chapter. Inpatient hospital services **also** are subject to the provisions regarding the limit **on** inpatient mental health services.

b. Authorized substance use disorder treatment. Only those services provided by **CHAMPUS-authorized** institutional, providers are covered. **Such** a provider must be either an authorized hospital, or an organized substance use disorder treatment program in an authorized free-standing or hospital-based substance use disorder rehabilitation facility. Covered services consist of any or all of the services listed below. A qualified mental health provider (physicians, clinical psychologists, clinical social workers, psychiatric nurse specialists) (see paragraph C.3.i. of this chapter) shall prescribe the particular level of treatment. Each CHAMPUS beneficiary is entitled to three substance use disorder treatment benefit periods in his or her lifetime, unless this limit is waived pursuant to paragraph E.4.e. of this chapter. (A benefit period begins with the first date of covered treatment and ends 365 days later, regardless of the total services actually used within the benefit. period. Unused benefits cannot be carried over to subsequent benefit periods. Emergency and inpatient hospital services (as described in paragraph E.4.a. of this chapter) do not constitute substance abuse treatment for purposes of establishing the beginning of a benefit **period.**)

(1) Rehabilitative care. Rehabilitative care in an authorized hospital or substance use disorder rehabilitative facility, whether free-standing or hospital-based, is covered on either a residential or partial care (day or night program) basis. Coverage during a single benefit period is limited to no more than one inpatient stay (exclusive of stays classified in DRG 433) in hospitals subject to CHAMPUS **DRG-based** payment system or 21 days in a **DRG-exempt** facility for rehabilitation care, unless the limit is waived pursuant to paragraph E.4.e. **of** this chapter. If the patient is medically in need of chemical detoxification, but does not require the personnel or facilities of a general hospital setting, detoxification services are covered in addition to the rehabilitative care, but in a **DRG-exempt** facility detoxification services are limited to 7 days, unless the limit is waived pursuant to paragraph E.4.e. of this chapter. The medical necessity for the detoxification must **be** documented. Any detoxification services provided by the substance use disorder rehabilitation facility must be under general medical supervision.

(2) Outpatient care. Outpatient treatment provided by an approved substance use disorder rehabilitation facility, whether free-standing or hospital-based, is covered for up to 60 visits in a benefit period, unless the **limit** is waived pursuant to paragraph E.4.e. of this chapter.

(3) Family therapy. Family therapy provided by an approved substance use disorder rehabilitation facility, whether free-standing or hospital-based, is covered for up to 15 visits in a benefit period, unless the limit is waived pursuant to paragraph E.4.e. of this chapter.

c. Exclusions

(1) Aversion therapy. The programmed use of physical measures, such as electric shock, alcohol, or other drugs as negative reinforcement (aversion therapy) is not covered, even if recommended by a physician.

(2) Domiciliary settings. Domiciliary facilities, generally referred to as halfway or quarterway houses, are not authorized providers and charges for services provided by these facilities are not covered.

d. Confidentiality. Release of any patient identifying information, including that required to adjudicate a claim, must comply with the provisions of section 544 of the Public Health Service Act, as amended, (42 U.S.C. 290dd-3), **which** governs the release of medical and other information from the records of patients undergoing treatment of substance abuse. If the patient refuses to authorize the release of medical records which are, in the opinion of the Director, **OCHAMPUS**, or a designee, necessary to determine benefits on a claim for treatment of substance abuse the claim will be denied.

e. Waiver of benefit limits. The specific benefit limits set forth in paragraphs **E.4.b.** of this chapter may be waived by the Director, **OCHAMPUS** in special cases based on a determination that all of the following criteria are met:

(1) Active treatment has taken place during the period of the benefit limit and substantial progress has been made according to the plan of treatment.

(2) Further progress has been delayed due to the complexity of the illness.

(3) Specific evidence has been presented to explain the factors that interfered with further treatment progress during the period of the benefit limit.

(4) The waiver request includes specific time frames and a specific plan of treatment which will complete the course of treatment.

5. Organ transplants. Basic Program benefits are available for otherwise covered services or **supplies** in connection with an organ transplant procedure, provided such transplant procedure generally is in accordance with accepted professional medical standards **and** is not considered to be experimental or investigational.

a. Recipient costs. CHAMPUS benefits are payable for recipient costs when the recipient of the transplant is a beneficiary, whether or not the donor is a beneficiary.

b. Donor costs

(1) Donor costs are payable when both the donor and recipient are CHAMPUS beneficiaries.

"(2) Donor costs are payable when the donor is a CHAMPUS beneficiary but the recipient is not.

(3) Donor costs are payable when the donor is the sponsor and the recipient is a beneficiary. (In such an event, donor costs are paid as a part of the beneficiary and recipient costs.)

(4) Donor costs also are payable when the donor is neither a CHAMPUS beneficiary nor a sponsor, if the recipient **is** a CHAMPUS beneficiary. (Again, in such an event, donor costs are paid as a part of the beneficiary and recipient costs.)

c. General limitations

(1) If the donor is not a beneficiary, CHAMPUS benefits for donor costs are limited to those directly related to the transplant procedure itself and do not include any medical care costs related to other treatment of the **donor**, including complications.

(2) In most instances, for costs related to kidney transplants, Medicare (not CHAMPUS) benefits will be applicable. If a CHAMPUS beneficiary participates as a kidney donor for a Medicare beneficiary, Medicare will pay for expenses in connection with the kidney transplant to include all reasonable preparatory, operation and postoperation recovery expenses associated with the donation (postoperative recovery expenses are limited to the actual period of recovery) . (Refer to paragraph E.3.f. of Chapter 3 of this Regulation. )

(3) Donor transportation costs are excluded whether or not the donor is a beneficiary.

(4) When the organ transplant is performed under a study, grant, or research program, no CHAMPUS benefits are payable for either recipient or donor cost .

d. Kidney acquisition. With specific reference to acquisition costs for kidneys, each hospital that performs kidney transplants is required for Medicare purposes to develop for each year separate standard acquisition costs for kidneys obtained from live donors and kidneys obtained from cadavers. The standard acquisition cost **for** cadaver kidneys is **compiled by** dividing the total cost of cadaver kidneys acquired by the number of transplants using cadaver kidneys. The standard acquisition cost for kidneys from live donors is compiled similarly using the total acquisition cost of kidneys from live donors and the number of transplants using kidneys from live donors. All recipients of cadaver kidneys are charged the same standard cadaver kidney acquisition cost and all recipients of kidneys from live donors are charged the same standard live donor acquisition cost. The appropriate hospital standard kidney acquisition costs (live donor or cadaver) required for Medicare in every instance must **be** used as the acquisition cost for purposes of providing CHAMPUS benefits.

e. Liver transplants. Effective July 1, 1983, CHAMPUS benefits are payable for services and supplies related to liver transplantation under the following circumstances only:

(1) Medical indications for liver transplantation. CHAMPUS shall provide benefits for services and supplies related to liver transplantation performed for beneficiaries suffering from irreversible liver injury who have exhausted alternative medical and surgical treatments, who are approaching the terminal phase of their illness, and who are considered appropriate for liver transplantation according to guidelines adopted by the Director, OCHAMPUS.

( 2 ) Contraindications. CHAMPUS shall not provide coverage if any of the following contraindications exist:

- (a) Active alcohol or other substance abuse;
- (b) Malignancies metastasized to or extending beyond the margins of the liver; or
- (c) Viral-induced liver disease when **viremia** is still present.

( 3 ) Specific covered services. CHAMPUS shall provide coverage for the following services related to liver transplantation:

- (a) Medically necessary services to evaluate a potential candidate's suitability for liver transplantation, whether or not the patient is ultimately accepted as a candidate for transplantation;
- (b) Medically necessary **pre-** and post-transplant inpatient hospital and outpatient services;
- (c) Surgical services and related **pre-** and post-operative services of the transplant team;
- (d) Services provided by a donor organ acquisition team, including the costs of transportation to the location of the donor organ and transportation of the team and the donated organ to the location of the transplantation center;
- (e) Medically necessary services required to maintain the viability of the donor organ following a formal declaration of brain death and after all existing legal requirements for excision of the donor organ have been met;
- (f) Blood and blood products;
- (g) Services and drugs required for immunosuppression, provided the drugs are approved by the United States Food and Drug Administration;
- (h) Services and supplies, including inpatient care, which are medically necessary to **treat** complications of the transplant procedure, including management of infection and rejection episodes; and

(i) Services and supplies which are medically necessary for the periodic evaluation and assessment of the successfully transplanted patient.

(4) Specific noncovered services. CHAMPUS benefits will not be paid for the following:

(a) Services and supplies for which the beneficiary has no legal obligation to pay. For example, CHAMPUS shall not reimburse expenses that are waived by the transplant center, or for which research funds are available; and

(b) Out-of-hospital living expenses and any other non-medical expenses, including transportation, of the liver transplant candidate or family members, whether pre- or post-transplant.

(5) Implementation guidelines. The Director, OCHAMPUS, shall issue such guidelines as are necessary to implement the provision of this paragraph.

f. Heart Transplantation. CHAMPUS benefits are payable for services and supplies related to heart transplantation under the following circumstances:

(1) Medical indications for heart transplantation. CHAMPUS shall provide benefits for services and supplies related to heart transplantation performed for beneficiaries with end-stage cardiac disease who have exhausted alternative medical and surgical treatments, who have a very poor prognosis as a result of poor cardiac functional status, for whom plans for long-term adherence to a disciplined medical regimen are feasible, and who are considered appropriate for heart transplantation according to guidelines adopted by the Director, OCHAMPUS. However, benefits for heart transplantation are available only if the procedure is performed in a CHAMPUS-approved heart transplantation center or meets other certification or accreditation standards recognized by the Director, OCHAMPUS. See Chapter 6, paragraph B.4.c. of this Regulation.

(2) Specific covered services. CHAMPUS shall provide coverage for the following services related to heart transplantation:

(a) Medically necessary services to evaluate a potential candidate's suitability for heart transplantation, whether or not the patient is ultimately accepted as a candidate for transplantation;

(b) Medically necessary pre- and post-transplant inpatient hospital and outpatient services;

(c) Surgical services and related pre- and post-operative services of the transplant team;

(d) Services provided by the donor acquisition team, including the costs of transportation to the location of the donor organ and transportation of the team and the donated organ to the location of the transplantation center;

(e) Medically necessary services required to maintain the viability of the donor organ following a formal declaration of brain death and after all existing legal requirements for excision of the donor organ have been met;

(f) Blood and **blood** products;

(g) Services and drugs required for immunosuppression, provided the drugs are approved by the United States Food and Drug Administration;

(h) Services and supplies, including inpatient care, which are medically necessary to treat complications of the transplant procedure, including management of infection and rejection episodes; and

(i) Services and supplies which are medically necessary for the periodic evaluation and assessment of the successfully transplanted patient.

(3) Noncovered services. CHAMPUS benefits will not be paid for the following:

(a) Services and supplies for which the beneficiary has no legal obligation to pay; and

(b) Out-of-hospital living expenses and any other non-medical expenses, including transportation of the heart transplant candidate or family members, whether **pre-** or post-transplant.

(4) Implementation guidelines. The Director, OCHAMPUS, shall issue such guidelines as are necessary to implement the provisions of this paragraph.

**6. Eyeglasses, spectacles, contact lenses or other optical devices.** Eyeglasses, spectacles, contact lenses, or other optical devices are excluded under the Basic Program except under very limited and specific circumstances.

a. Exception to general exclusion. Benefits for glasses and lenses may be extended only in connection with the **following** specified eye conditions and circumstances:

(1) Eyeglasses or lenses that perform the function of the human lens, lost as the result of intraocular surgery or ocular **injury** or congenital absence.

NOTE : Notwithstanding the general requirement for U.S. Food and Drug Administration approval of any surgical implant set forth in paragraph D.3.g. of this chapter, intraocular lenses are authorized under CHAMPUS if they are either approved for marketing by the FDA or are subject to an investigational device exemption.

(2) 'Pinhole" glasses prescribed for use after surgery for detached retina.

(3) Lenses prescribed as "treatment" instead of surgery for the following conditions:

(a) Contact lenses used for treatment of infantile glaucoma.



(b) **Corneal** or **scleral** lenses prescribed in connection with treatment of **keratoconus**.

(c) **Scleral** lenses prescribed to retain moisture when normal tearing is not present or is inadequate.

(d) **Corneal** or **scleral** lenses prescribed to reduce a **corneal** irregularity other than astigmatism.

b. Limitations. The specified benefits are limited further to one set of lenses related to one of the qualifying eye conditions set forth in paragraph E.6.a., above. If there is a prescription change requiring a new set of lenses (but still related to the qualifying eye condition), benefits may be extended for a second set of lenses, subject to specific medical review.

7. Transsexualism or such other conditions as gender dysphoria. All services and supplies directly or indirectly related to transsexualism or such other conditions as gender **dysphoria** are excluded under CHAMPUS. This exclusion includes, but is not limited to, psychotherapy, prescription drugs, and intersex surgery that may be provided in connection with transsexualism or such other conditions as gender **dysphoria**. There is only one very limited exception to this general exclusion, that is, notwithstanding the definition of congenital anomaly, CHAMPUS benefits may be extended for surgery and related medically necessary services performed to correct sex gender confusion (that is, ambiguous genitalia) which has been documented to **be** present at birth.

8. Cosmetic, reconstructive, or plastic surgery. For the purposes of CHAMPUS, cosmetic, reconstructive, or plastic surgery is surgery that can be expected primarily to improve physical appearance or that is performed primarily for psychological purposes or that restores form, but does not correct or improve materially a bodily function.

NOTE : If a surgical procedure primarily restores function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions set forth in this subsection E.8.

a. Limited benefits under CHAMPUS. Benefits under the Basic Program generally are **not** available for cosmetic, reconstructive, or plastic surgery. However, under certain limited circumstances, benefits for otherwise covered services and supplies may **be** provided in connection with cosmetic, reconstructive, or plastic surgery as follows:

- (1) Correction of a congenital anomaly; or
- (2) Restoration of body form following an accidental injury; or
- (3) Revision of disfiguring and extensive scars resulting from **neoplastic** surgery.

(4) Reconstructive breast surgery following a medically necessary mastectomy performed for the treatment of carcinoma, severe **fibrocystic** disease, other nonmalignant tumors or traumatic injuries.

(5) Penile implants and testicular prostheses for conditions resulting from organic origins (i.e., trauma, radical surgery, disease process, for correction of congenital anomaly, etc.). Also penile implants for organic impotency.

NOTE : Organic impotence is defined as that which can be reasonably expected to occur following certain diseases, surgical procedures, trauma, injury, or congenital malformation. Impotence does not become organic because of psychological or psychiatric reasons.

(6) Generally, benefits are limited to those cosmetic, reconstructive, or plastic surgery procedures performed no later than December 31 of the year following the year in which the related accidental injury or surgical trauma occurred, except for authorized postmastectomy breast reconstruction for which there is no time limitation between mastectomy and reconstruction. Also, special consideration for exception will be given to cases involving children who may require a growth period.

b. General exclusions

(1) For the purposes of CHAMPUS, dental congenital anomalies such as absent tooth buds or malocclusion specifically are excluded. Also excluded are any procedures related to transsexualism or such other conditions as gender dysphoria except as provided in subsection **E.7.**, above.

(2) Cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process also are excluded.

(3) Procedures performed for elective correction of minor **dermatological** blemishes and marks or minor anatomical anomalies also are excluded.

(4) In addition, whether or not it would otherwise qualify for benefits under paragraph E.8.a., above, the breast augmentation **mammoplasty** is specifically excluded.

c. **Noncovered** surgery, all related services and **supplies** excluded. When it is determined that a cosmetic, reconstructive, or plastic surgery procedure does not qualify for CHAMPUS benefits, all related services and supplies are excluded, including any institutional costs.

d. **Examples of noncovered cosmetic, reconstructive, or plastic surgery procedures.** The following is a partial list of cosmetic, reconstructive, or plastic surgery procedures that do not qualify for benefits under CHAMPUS. This **list** is for example purposes only and is not to be construed as being all-inclusive.

(1) Any procedure performed for personal reasons to improve the appearance of an obvious feature or part of the body that would be considered by **an-average observer to be normal and acceptable for the patient's age or ethnic-or racial background.**

(2) Cosmetic, reconstructive, or plastic surgical procedures that are justified primarily on the basis of a psychological **or** psychiatric need.

(3) **Augmentation mammoplasties**, except for those performed as a part of postmastectomy breast reconstruction as specifically authorized in subparagraph **E.8.a.(4)** of this chapter.

(4) Face lifts and other procedures related to the aging process.

(5) Reduction **mammoplasties** (unless there is medical documentation of intractable pain, not amenable to other forms of treatment, resulting from large, pendulous breasts).

(6) **Panniculectomy**; body sculpture procedures.

(7) Repair of sagging eyelids (without demonstrated and medically documented significant impairment of vision).

(8) Rhinoplasties (without evidence of accidental injury occurring within the previous 6 months that resulted in significant obstruction of breathing).

(9) Chemical peeling for facial wrinkles.

(10) **Dermabrasion** of the face.

(11) Elective correction of minor **dermatological** blemishes and marks or minor anatomical anomalies.

(12) Revision of scars resulting from surgery or a disease process, **except disfiguring** and extensive scars resulting from **neoplastic** surgery.

(13) Removal of tattoos.

(14) Hair transplants.

(15) Electrolysis.

(16) Any procedures related to transsexualism or such other conditions as gender **dysphoria** except as provided in subsection E.7. of this chapter.

(17) Penile implant procedure for psychological impotency, transsexualism or such other conditions as gender **dysphoria**.

(18) Insertion of prosthetic testicles for transsexualism or such other conditions as gender **dysphoria**.

9. Complications (unfortunate sequelae) resulting from noncovered initial surgery or treatment. Benefits are available for otherwise covered services and supplies required in the treatment of complications resulting from a noncovered incident of treatment (such as **nonadjunctive** dental care, transsexual surgery, and cosmetic surgery) but only if the later complication represents a separate medical condition such as a systemic infection, cardiac arrest, and acute drug reaction. Benefits may not be extended for any later care or procedures related to the complication that essentially is similar to the initial noncovered care. Examples of complications similar to the initial episode of care (and thus not covered) would be repair of facial scarring resulting from **dermabrasion** for acne or repair of a **prolapsed** vagina in a biological male who had undergone transsexual surgery.

10. Dental. CHAMPUS does not include a dental benefit. Under very limited circumstances, benefits are available for dental services and supplies when the dental services are **adjunctive** to otherwise covered medical treatment.

a. Adjunctive dental care, limited. Adjunctive dental care is limited to those services and supplies provided under the following conditions:

(1) Dental care which is medically necessary in the treatment of an otherwise covered medical (not dental) condition, is an integral part of the treatment of such medical condition and is essential to the control of the primary medical condition. The following is a list of conditions for which CHAMPUS benefits are payable under this provision:

- (a) Intraoral abscesses which extend beyond the dental alveolus.
- (b) Extraoral abscesses.
- (c) **Cellulitis** and osteitis which is clearly exacerbating and directly affecting a medical condition currently under treatment.
- (d) Removal of teeth and tooth fragments in order to treat and repair facial trauma resulting from an accidental injury.
- (e) **Myofacial** Pain Dysfunction Syndrome.
- (f) Total or complete **ankyloglossia**.
- (g) Adjunctive dental and orthodontic support for cleft palate.
- (h) The prosthetic replacement of either the maxilla or the mandible due to the reduction of body tissues associated with traumatic injury (e.g., impact, gun shot wound), in addition to services related to treating **neoplasms** or iatrogenic dental trauma.

NOTE : The test of whether dental trauma is covered is whether the trauma is solely dental trauma. Dental trauma, in order to be covered, must be related to, and an integral part of medical trauma; or a result of medically necessary treatment of an injury or disease.

(2) Dental care required in preparation for medical treatment of a disease or, disorder or required as the result of dental trauma caused by the medically necessary treatment-of an injury or disease (**iatrogenic**).

(a) Necessary dental care including prophylaxis and extractions when performed in preparation for or as a result of in-line radiation therapy for oral or facial cancer.

(b) Treatment of **gingival hyperplasia**, with or without periodontal disease, as a direct result of prolonged therapy with **Dilantin (diphenylhydantoin)** or related compounds.

(c) Dental care is limited to the above and similar conditions specifically prescribed by the Director, **OCHAMPUS**, as meeting the requirements for coverage under the provisions of this section.

b. General exclusions.

(1) Dental care which is routine, preventative, restorative, **prosthodontic**, periodontics or emergency does not qualify as **adjunctive** dental care for the purposes of CHAMPUS except when performed in preparation for or as a result of dental trauma caused by medically necessary treatment of an injury or disease.

(2) The adding or modifying of bridgework and dentures.

(3) Orthodontia, except when directly related to and an integral part of the medical or surgical correction of a cleft palate or when required in preparation for, or as a result of, trauma to the teeth and supporting structures caused by medically necessary treatment of an injury or disease.

c. Pre.authorization required. In order to be covered, adjunctive dental care requires **preauthorization from** the Director, **OCHAMPUS**, or a designee, in accordance with subsection All. of this chapter. When adjunctive dental care involves a medical (not dental) emergency (such as facial injuries resulting from an accident), the requirement for preauthorization is waived. Such waiver, however, is limited to the essential **adjunctive** dental care related to the medical condition requiring the immediate emergency treatment. A complete explanation, with supporting medical documentation, must be submitted with claims for emergency **adjunctive** dental care.

d. Covered oral surgery. Notwithstanding the above limitations on dental care, there are certain **oral surgical** procedures that are performed by both physicians and dentists, and that are essentially medical rather than dental care. For the purposes of CHAMPUS, the following procedures, whether performed by a physician or dentist, are considered to be in this category and benefits may be extended for otherwise covered services and supplies without preauthorization:

(1) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, and roof and floor of the mouth, when such conditions require a pathological (histological) examination.

(2) Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, and roof and floor of the mouth.

(3) Treatment of oral or facial cancer.

(4) Treatment of fractures of facial bones.

(5) External (extra-oral) incision and drainage of cellulitis.

(6) Surgery of accessory sinuses, salivary glands, or ducts.

(7) Reduction of dislocations and the excision of the temporomandibular joints, when surgery is a necessary part of the reduction.

(8) Any oral surgical procedure that falls within the cosmetic, reconstructive, or plastic surgery definition is subject to the limitations and requirements set forth in subsection E.8. of this chapter.

NOTE : Extraction of unerupted or partially erupted, malposed or impacted teeth, with or without the attached follicular or development tissues, is not a covered oral surgery procedure except when the care is indicated in preparation for medical treatment of a disease or disorder or required as a result of dental trauma caused by the necessary medical treatment of an injury or illness. Surgical preparation of the mouth for dentures is not covered by CHAMPUS .

e.. Inpatient hospital stay in connection with nonadjunctive, noncovered dental care. Institutional benefits specified in section B. of this chapter may be extended for inpatient hospital stays related to noncovered, nonadjunctive dental care when such inpatient stay is medically necessary to safeguard the life of the patient from the effects of dentistry because of the existence of a specific and serious nondental organic impairment currently under active treatment. (Hemophilia is an example of a condition that could be considered a serious nondental impairment.) Preauthorization by the Director, OCHAMPUS, or a designee, is required for such inpatient stays to be covered in the same manner as required for adjunctive dental care described in paragraph E.10.C. of this chapter. Regardless of whether or not the preauthorization request for the hospital admission is approved and thus qualifies for institutional benefits, the professional service related to the nonadjunctive dental care is not covered.

11. Drug abuse. Under the Basic Program, benefits may be extended for medically necessary prescription drugs required in the treatment of an illness or injury or in connection with maternity care (refer to section D. of this chapter). However, CHAMPUS benefits cannot be authorized to support or maintain an existing or potential drug abuse situation, whether or not the drugs (under other circumstances) are eligible for benefit consideration and whether or not obtained by legal means.

a. Limitations on who can prescribe drugs. CHAMPUS benefits are not available for any drugs prescribed by a member of the beneficiary's family or by a **nonfamily** member residing in the same household with the beneficiary or sponsor.

b. Drug maintenance programs excluded. Drug maintenance programs when one addictive drug is substituted for another on a maintenance basis (such as methadone substituted for heroin) are not covered. This exclusion applies even **in** areas outside the United States where addictive drugs are dispensed legally by physicians on a maintenance dosage level.

c. Kinds of prescription drugs that are monitored carefully by CHAMPUS for possible abuse situations.

(1) Narcotics. Examples are Morphine and Demerol.

(2) Nonnarcotic analgesics. Examples are Talwin and Darvon.

(3) Tranquilizers. Examples are Valium, Librium, and Meproamate.

(4) Barbiturates. Examples are Seconal and Nembutal.

(5) Nonbarbiturate hypnotics. Examples are Doriden and Chloral Hydrate.

(6) Stimulants. Examples are amphetamines.

d. CHAMPUS fiscal intermediary responsibilities. CHAMPUS fiscal intermediaries are responsible for implementing utilization control and quality assurance procedures designed to identify possible drug abuse situations. The CHAMPUS fiscal intermediary is directed to screen all drug claims for potential overutilization and irrational prescribing of drugs, and to subject any such cases to extensive review to establish the necessity for the drugs and their appropriateness on the basis of diagnosis or definitive symptoms.

(1) When a possible drug abuse situation is identified, **all** claims for drugs for that specific beneficiary or provider will be suspended pending the results of a review.

(2) If the review determines that a drug abuse situation does in fact exist, all drug claims held in suspense will be denied.

(3) If the record indicates previously paid drug benefits, the prior claims for that beneficiary or provider will be reopened and the circumstances involved reviewed to determine whether or not drug abuse also existed at the time the earlier claims were adjudicated. If drug abuse is later ascertained, benefit payments made previously will be considered to have been extended in error and the amounts so paid recouped.

(4) Inpatient stays primarily for the purpose of obtaining drugs and any other services and supplies related to drug abuse also are excluded.

e. Unethical or illegal provider practices related to drugs. Any such investigation into a possible drug abuse **that** uncovers unethical or illegal drug dispensing practices on the part of an institution, a pharmacy, or physician will be referred to the professional or investigative agency having jurisdiction. **CHAMPUS fiscal intermediaries are directed to withhold payment of all CHAMPUS claims for services and supplies rendered by a provider under active investigation for possible unethical or illegal drug dispensing activities.**

f. Detoxification. The above monitoring and control of drug abuse **situations** shall in no way **be** construed to deny otherwise covered medical services and supplies related to drug detoxification (including newborn, addicted infants) when medical supervision is required.

12. Custodial care. The statute under which CHAMPUS operates specifically excludes custodial care. Many beneficiaries and sponsors misunderstand what is meant by custodial care, assuming that because custodial care is not covered, it implies the custodial care is not necessary. This is not the case; it only means the care being provided is not a type of care for which CHAMPUS benefits can be extended.

a. Kinds of conditions that can result in custodial care. There is no absolute rule that can be applied. With most conditions, there is a period of active treatment before custodial care, some much more prolonged than others. Examples of potential custodial care cases may be a spinal cord injury resulting in extensive paralysis, a severe cerebral vascular accident, multiple sclerosis in its latter stages," or presenile and senile dementia. These conditions do not result necessarily in custodial care but are indicative of the types of conditions that sometimes do. It is not the condition itself that is controlling, but whether the care being rendered falls within the definition of custodial care (refer to Chapter 2 of this Regulation for the definition of 'custodial care").

b. Benefits available in connection with a custodial care case. CHAMPUS **benefits** are not available for **services** related **to** a custodial care case, with the following specific exceptions:

(1) Prescription drugs and medicines, medical supplies and durable medical equipment. Benefits are payable for otherwise covered prescription drugs and medicines, medical supplies and durable medical equipment.

(2) Nursing services, limited. Recognizing that even though the care being received is determined primarily to be custodial, an occasional specific skilled nursing service may **be** required. When it is determined such skilled nursing services are needed, benefits may be extended for 1 hour of nursing care per day.

(3) Physician services, limited. Recognizing that even though the care being received—is determined primarily to **be** custodial, occasional physician monitoring may be required to maintain the patient's condition. When it is determined that a patient is receiving custodial care, benefits may be extended for up to twelve physician visits per calendar year for the custodial condition (not to exceed one per month).



NOTE : CHAMPUS benefits may be extended for additional physician visits related **to** the treatment of a condition other than the condition for which the patient is receiving custodial care (an example is a broken leg as a result of a fall).

(4) Payment for prescription drugs, medical supplies, durable medical equipment and limited skilled nursing and physician services does not affect custodial care determination. The fact that CHAMPUS extends benefits for prescription drugs, medical supplies, durable medical equipment, and limited skilled nursing and physician services in no way affects the custodial care determination if the case otherwise falls within "the definition of custodial care."

c. Exception to custodial care exclusion, admission to a hospital. CHAMPUS benefits may be extended for otherwise covered services or supplies directly related to a medically necessary admission to an acute care general or special hospital (as defined in paragraph B.4.a., Chapter 6, of this Regulation), if the care is at the appropriate level and meets other requirements of this Regulation.

d. Reasonable care for which benefits were authorized or reimbursed before June 1, 1977. It is recognized that care for which benefits were authorized or reimbursed before the implementation date of the Regulation may **be** excluded under the custodial care limitations set forth in this Regulation. Therefore, an exception to the custodial care limitations set forth in this Regulation exists whereby reasonable care for which benefits authorized or reimbursed under the Basic Program before June 1, 1977, shall continue to be authorized even though the care **would** be excluded as a benefit under the custodial care limitations of the Regulation. Continuation of CHAMPUS benefits in such cases is limited as follows:

(1) Initial authorization or reimbursement before June 1, 1977. The initial CHAMPUS-authorization or reimbursement for the care occurred before June 1, 1977; and,

(2) Continued care. The care has been continuous since the initial CHAMPUS authorization or **reimbursement**; and,

(3) Reasonable care. The care is reasonable. CHAMPUS benefits shall be continued for reasonable care up to the same level of benefits and for the same period of eligibility authorized or reimbursed before June 1, 1977. Care that is excessive or otherwise unreasonable will be reduced or eliminated from the continued care authorized under this exception.

13. Domiciliary care. The statute under which CHAMPUS operates also specifically excludes domiciliary care (refer to Chapter 2 of this Regulation for the definition of "Domiciliary Care").

a. Examples of domiciliary care situations. The following are examples of domiciliary care for which CHAMPUS benefits are **not** payable.

(1) Home care is not available. Institutionalization primarily because parents **work**, or extension of a hospital stay beyond what is medically necessary because the patient lives alone, are examples of domiciliary care provided because there is no other family member or other person available in the home.

(2) Home care is not suitable. Institutionalization of a child because a parent (or parents) is an alcoholic who is not responsible enough to care for the child, or because someone in the home has a contagious disease, are examples of domiciliary care being provided because the home setting is unsuitable.

(3) Family unwilling to care for a person in the home. A child who is difficult to manage may be placed **in** an institution, not because institutional care is medically necessary, but because the family does not want to handle him or her in the home. Such "institutionalization would represent domiciliary care, that is, the family being unwilling to "assume responsibility for the child.

**b.** Benefits available in connection with a domiciliary care case. Should the beneficiary receive **otherwise** covered medical services or supplies **while** also being in a domiciliary care situation, CHAMPUS benefits are payable for those medical services or supplies, or both, in the same manner as though the beneficiary resided in his or her own home. Such benefits would be cost-shared as though rendered to an outpatient.

**c.** General exclusion. Domiciliary care is institutionalization essentially to provide a substitute home--not because it is medically necessary for the beneficiary to be in the institution (although there may be conditions present that have contributed to the fact that domiciliary care **is** being rendered). CHAMPUS benefits are not payable for any costs or charges related to the provision of domiciliary care. While a substitute home or assistance may be necessary for the beneficiary, domiciliary care does not represent the kind of care for which CHAMPUS benefits can **be** provided.

#### 14. CT scanning

**a.** Approved CT scan services. Benefits may be extended for medically necessary CT scans of the head or other anatomical regions of the body when all of the following conditions are met:

(1) The patient is referred for the diagnostic **procedure** by a physician.

(2) The CT scan procedure is consistent with the preliminary diagnosis or symptoms.

(3) Other **noninvasive** and less costly means of diagnosis have been attempted or are not appropriate.

(4) The CT scan equipment. is licensed or registered by the appropriate state agency responsible for licensing or registering medical equipment that emits ionizing radiation.

(5) The CT scan equipment is operated under the general supervision and direction of a physician,

(6) The results of the CT scan diagnostic procedure are interpreted by a physician.

b. Review guidelines and criteria. The Director, OCHAMPUS, or a designee, will issue specific guidelines and criteria for CHAMPUS coverage of medically necessary head and body part CT scans.

15. Morbid obesity. The CHAMPUS morbid obesity benefit is limited to the gastric bypass, gastric stapling, or **gastroplasty** method.

a. Conditions for coverage. Payment may be extended for the gastric bypass, gastric stapling, or **gastroplasty** method only when one of the following conditions is met:

(1) The patient is 100 pounds over the ideal weight for height and bone structure and has an associated severe medical condition. These associated medical conditions are diabetes **mellitus**, hypertension, **cholecystitis**, narcolepsy, **pickwickian** syndrome (and other severe respiratory diseases), hypothalamic disorders, and severe arthritis of the weight-bearing joints.

(2) The patient is 200 percent or more of the ideal weight for height and bone structure. An associated medical condition is not required for this category.

(3) The patient has had an intestinal bypass or other surgery for obesity and, because of complications, requires a second surgery (a takedown). The surgeon in many cases, will do a gastric bypass, gastric stapling, or **gastroplasty** to help the patient avoid regaining the weight that was lost. In this situation, payment is authorized even though the patient's condition technically may not meet the definition of morbid obesity because of the weight that was already lost following the initial surgery.

b. Exclusions

(1) CHAMPUS payment may not be made for nonsurgical treatment of obesity or morbid obesity, for dietary control, or weight reduction.

(2) CHAMPUS payment may not be made for surgical procedures other than the gastric bypass, gastric stapling, or **gastroplasty**, even if morbid obesity is present.

16. Maternity care.

a. Benefit. The CHAMPUS Basic Program may share the cost of medically necessary services and supplies associated with maternity care which are not otherwise excluded by this Regulation. However, failure by a beneficiary to secure a required **Nonavailability** Statement (**NAS**) (DD Form 1251) as set forth in subsection A. 9. of this Chapter will waive that beneficiary's right to CHAMPUS cost-share of certain maternity care services and supplies.

b. Cost-share. Subject to applicable **NAS** requirements, maternity care cost-share shall be determined as follows:

(1) Inpatient cost-share formula applies to maternity care ending in childbirth in, or on the way to, a hospital inpatient childbirth unit, and for maternity care ending in a non-birth outcome not otherwise excluded by this Regulation.

(2) Ambulatory surgery **cost-share** formula applies to maternity care ending in childbirth in, or on the way to, a birthing center to which the beneficiary is admitted and from which the beneficiary has received prenatal care, or a hospital-based outpatient birthing room.

(3) Outpatient cost-share formula applies to maternity care which terminates in a planned childbirth at home.

(4) Otherwise covered medical services and supplies directly related to "Complications of Pregnancy," as defined in Chapter 2 will be cost-shared on the same basis as the related maternity care for a period not to exceed 42 days following termination of the pregnancy and thereafter cost-shared on the basis of the inpatient or outpatient status of the beneficiary when medically necessary services and supplies are received.

17. Biofeedback Therapy. Biofeedback therapy is a technique by which a person is taught to exercise control over a physiologic process occurring within the body. By using modern biomedical instruments the patient learns how a specific physiologic system within his body operates and how to modify the performance of this particular system.

a. Benefits provided. CHAMPUS benefits are payable for services and supplies in connection with electrothermal, **electromyograph** and **electrodermal** biofeedback therapy when there is documentation that the patient has undergone an appropriate medical evaluation, that their present condition is not responding to or no longer responds to other forms of conventional treatment, and only when provided as treatment for the following conditions:

(1) Adjunctive treatment for **Raynaud's** Syndrome.

(2) Adjunctive treatment for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of **spasticity**, or incapacitating muscle spasm or weakness.

b. Limitations. Payable benefits include initial intake evaluation. Treatment following the initial intake evaluation is limited to a maximum of 20 inpatient and outpatient biofeedback treatments per calendar year.

c. Exclusions. Benefits are excluded for biofeedback therapy for the treatment of ordinary muscle tension states or for psychosomatic conditions. Benefits are also excluded for the rental or purchase of biofeedback equipment.

d. Provider requirements. A provider of biofeedback therapy must be a CHAMPUS-authorized provider. (Refer to CHAPTER 6, "Authorized Providers.") If biofeedback treatment is provided by other than a physician, the patient must be referred by a physician.

e. Implementation Guidelines. The Director, **OCHAMPUS**, shall issue guidelines as are necessary to implement the provisions of this paragraph.

18. Cardiac Rehabilitation. Cardiac rehabilitation is the process by which individuals are restored to their optimal physical, medical and psychological status, after a cardiac event. Cardiac rehabilitation is often divided into three phases. Phase I begins during inpatient hospitalization and is managed by the patient's personal physician. phase II is a medically supervised outpatient program which begins following discharge. Phase III is a lifetime maintenance program emphasizing continuation of physical fitness with periodic **followup**. Each phase includes an exercise component, patient education, and risk factor modification. There may be considerable variation in program components, intensity and duration.

a. Benefits Provided. CHAMPUS benefits are available on an inpatient or outpatient basis for services and supplies provided in connection with a cardiac rehabilitation program when ordered by a physician and provided as treatment for patients who have experienced the-following cardiac events within the preceding twelve (12) months:

- (1) **Myocardial** Infarction.
- (2) Coronary Artery Bypass Graft.
- (3) Coronary **Angioplasty**.
- (4) Percutaneous **Transluminal** Coronary **Angioplasty**.
- (5) Chronic Stable Angina (see limitations below).

b. Limitations. Payable benefits include separate allowance for the initial **evaluation** and testing. Outpatient treatment following the initial intake evaluation and testing is limited to a maximum of thirty-six (36) sessions per cardiac event, usually provided 3 sessions per week for twelve weeks. Patient's diagnosed with chronic stable angina are limited to one treatment episode (36 sessions) in a calendar year.

c. Exclusions. Phase III cardiac rehabilitation lifetime maintenance programs performed at **home** or in medically unsupervised settings are not covered.

d. Providers. A provider of cardiac rehabilitation services must be a **CHAMPUS** authorized hospital. (Refer to Chapter 6, 'Authorized Providers.") All cardiac rehabilitation services must be ordered **by** a physician.

e. Payment. Payment for outpatient treatment will be based on an all inclusive allowable charge per session. Inpatient treatment will be paid based upon the reimbursement system in place for the hospital where the services are rendered.

f. Implementation Guidelines: The Director of OCHAMPUS shall issue guidelines as **are** necessary to implement the provisions of this paragraph.

19. Hospice care. Hospice care is a program which provides an integrated set of services and supplies designed to care for the terminally ill. This type of care emphasizes palliative care and supportive services, such as pain control and home care, rather than cure-oriented services provided in institutions that are otherwise the primary focus under CHAMPUS. The benefit provides coverage for a humane and sensible approach to care during the last days of life for some terminally ill patients.

a. Benefit coverage. CHAMPUS beneficiaries who are terminally ill (that is, a life expectancy of six months or less if the disease runs its normal course) will be eligible for the following services and supplies in lieu of most other CHAMPUS benefits:

(1) Physician services.

(2) Nursing care provided by or under the supervision of a registered professional nurse.

(3) Medical social services provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician. Medical social services include, but are not limited to the following:

(a) Assessment of social and emotional factors related to the beneficiary's illness, need for care, response to treatment, and adjustment to care.

(b) Assessment of the relationship of the beneficiary's medical and nursing requirements to the individual's home situation, financial resources, and availability of community resources.

(c) Appropriate action to obtain available community resources to assist in resolving the beneficiary's problem.

(d) Counseling services that are required by the beneficiary.

(4) Counseling services provided to the terminally ill individual and the family member or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other care-giver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death. Bereavement counseling, which consists of counseling services provided to the individual's family after the individual's death, is a required hospice service but it is not reimbursable.

(5) Home health aide services furnished by qualified aides and homemaker services. Home health aides may provide personal care services. Aides also may perform household services to maintain a safe and sanitary environment in areas of the home used by the patient. Examples of such services are changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services must be provided under the general supervision of a registered nurse. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment, and services to enable the individual to carry out the plan of care. Qualifications for home health aides can be found in 42 C.F.R. section 484.36.

(6) Medical appliances and supplies, including drugs and biological. Only drugs that are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. Appliances may include covered durable medical equipment, as well as other self-help and personal comfort items related to the palliation or management of the patient's condition while he or she "is under hospice care. Equipment is provided by the hospice for use in the **beneficiary's** home while he **or** she is under hospice care. Medical supplies include those that are part of the written plan of care. Medical appliances and supplies are. included within the hospice all-inclusive rates.

(7) Physical therapy, occupational therapy and speech-language pathology services provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

(8) Short-term inpatient care provided in a Medicare participating hospice inpatient unit, or a Medicare participating hospital, skilled nursing facility (**SNF**) or, in the **case** of respite care, a Medicaid-certified nursing facility that additionally meets the special hospice standards regarding staffing and patient areas. Services provided in an inpatient setting must conform to the written plan of care. Inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home. Respite care is the only type of **inpatient** care that may be provided in a Medicaid-certified nursing facility. The limitations on custodial care and personal comfort items applicable to other CHAMPUS services are not applicable to hospice care.

b. Core services. The hospice must ensure that substantially all core services are routinely provided directly by hospice employees; i.e. , physician services, nursing care, medical social services, and counseling for individuals and care givers. Refer to paragraphs **E.19.a.(1)**, **E.19.a. (2)**, **E.19.a. (3)**, and **E.19.a. (4)** of this chapter.

c. Non-core services. While non-core services (i.e., home health aide services, medical appliances and supplies, drugs and biological, physical therapy, occupational therapy, speech-language pathology and short-term inpatient care) may **be** provided under arrangements with other agencies or organizations, the hospice must maintain professional management of the patient at all times and in all settings. Refer to paragraphs **E.19.a. (5)**, **E.19.a. (6)**, **E.19.a. (7)**, and **E.19.a. (8)** of this chapter.

d. Availability of services. The hospice must make nursing services, physician services, and drugs and biological routinely available on a 24-hour basis. All other covered services must be made available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary **for** the palliation and management of the terminal illness and related condition. These services must be provided in a manner consistent with accepted standards of practice.

e. Periods of care. Hospice care is divided into distinct **periods/episodes** of care. The terminally ill beneficiary may elect to receive hospice benefits for an initial period of 90 days, a subsequent period of 90 days, a second subsequent period of 30 days, and a final period of unlimited duration.

f. Conditions for coverage. The CHAMPUS beneficiary **must** meet the following **conditions/criteria** in order to be eligible for the hospice benefits and services referenced in paragraph **E.19.a.** of this chapter.

(1) There must be written certification in the medical record that the CHAMPUS beneficiary is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

(a) Timing of certification. The hospice must obtain written certification of terminal illness for each of the election periods described in paragraph **E.19.f. (2)** of this chapter, even if a single election continues in effect for two, three or four periods.

1 Basic **requirement.** Except as provided in paragraph **E.19.f. (1)(a)2** of this chapter, the hospice must obtain the written certification no later than two calendar days after the period begins.

2 Exception. For the initial 90-day period", if the hospice cannot obtain the written certifications within two calendar days, it must obtain oral certifications within two calendar days, and written certifications no later than eight calendar days after the period begins.

(b) Sources of certification. Physician certification is required for both initial and subsequent election periods.

1 For the initial 90-day period, the **hospice must obtain** written certification statements (and oral certification statements if required under paragraph **E.19.f. (1)(a)2** of this chapter) from:

a The individual's attending physician if the individual has an attending **physician**; and

b The medical director of **the hospice** or the physician member of the hospice interdisciplinary group.

2 For subsequent periods, the only requirement is certification by one of the physicians listed in paragraph **E.19.f. (1)(b)1 b** of this section.

(2) The terminally ill beneficiary must elect to receive hospice care **for** each specified period of time; i.e., the two 90-day periods, a subsequent **30-day** period, and a final period **of** unlimited duration. If the individual is found **to** be mentally incompetent, his or her representative may file the election statement. Representative means an individual who has been authorized under State law to terminate medical care or to elect or revoke the election of hospice care **on** behalf of a terminally ill individual who is found to be mentally incompetent.



(a) The episodes of care must be used consecutively; i.e., the two **90-day** periods first, then the 30-day period, followed **by** the final period. The periods of care may be elected separately at different times.

(b) The initial election will continue through subsequent election periods without a break in care as **long as** the individual remains in the care of the **hospice and** does not revoke the election.

(c) The effective date of the election may begin on the first day of hospice care or any subsequent day of care, but the effective date cannot be made prior **to** the date that the election was made.

(d) The beneficiary or representative may revoke a hospice election at any time, but in doing so, the remaining days of that particular election period are forfeited and standard CHAMPUS coverage resumes. To revoke the hospice benefit, the beneficiary or representative must file a signed statement of revocation with the hospice. The statement must provide the date that the revocation is to be effective. An individual or representative may not designate an effective date earlier than the date that the revocation is made.

(e) If an election of hospice benefits has been revoked, the individual, or his or her representative may at any time file a hospice election for any period of time still available to the individual, in accordance with Chapter **4.E.19.f.(2)**.

(f) A CHAMPUS beneficiary may change, once in each election period, the designation of the particular hospice from which he or she elects to receive hospice care. To change the designation of hospice programs the individual or representative must file, with the hospice from which care has been received and **with** the newly designated hospice, a statement that includes the following information:

1 The **name of** the hospice from which the individual has received care and the name of the hospice from which he or she plans to receive care.

2 The date the change is to be effective.

(g) Each hospice will design and print its own election statement to include the following information:

1 Identification of the particular hospice that will provide care to the individual.

2 The individual's or representative's acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the individual's terminal illness.

3 The individual's or representative's acknowledgment that he or she understands that certain other CHAMPUS services are waived **by** the election.

4 The effective date of the election.

5 The signature of the individual or representative, and the date signed.

(h) The hospice must notify the CHAMPUS contractor of the initiation, change or revocation of any election.

(3) The beneficiary must waive all rights to other CHAMPUS payments for the duration of the election period for:

(a) Care provided by any hospice program other than the elected hospice unless provided under arrangements made by the elected hospice; and

(b) Other CHAMPUS basic program services/benefits related to the treatment of the terminal illness for which hospice care was elected, or to a related condition, or that are equivalent to hospice care, except for services provided by:

1 the designated hospice;

2 another hospice under arrangements made by the designated hospice; or

3 an attending physician who is not employed by or under . . . contract with the hospice program.

(c) Basic CHAMPUS coverage will be reinstated upon revocation of the hospice election.

(4) A written plan of care must be established by a member of the basic interdisciplinary group assessing the patient's needs. This group must have at least one physician, one registered professional nurse, one social worker, and one pastoral or other counselor.

(a) In establishing the initial plan of care the member of the basic interdisciplinary group who assesses the patient's needs must meet or call at least one other group member before writing the initial plan of care.

(b) At least one of the persons involved in developing the initial plan must be a nurse or physician.

(c) The plan must be established on the same day as the assessment if the day of assessment is to be a covered day of hospice care.

(d) The other two members of the basic interdisciplinary group -- the attending physician and the medical director or physician designee -- must review the initial plan of care and provide their input to the process of establishing the plan of care within two calendar days following the day of assessment. A meeting of group members is not required within this 2-day period. Input may be provided **by** telephone.

..... (e) Hospice services must be consistent with the plan of care for coverage to be extended.

(f) The plan must be reviewed and updated, at intervals specified in the plan, by the attending physician, medical director or physician designee and interdisciplinary group. These reviews must be documented in the medical records.

(g) The hospice must designate a registered nurse to coordinate the implementation of the plan of care for each patient.

(h) The plan must include an assessment of the individual's needs and identification of the services, including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient's and family's needs.

(5) Complete medical records and all supporting documentation must be submitted to the CHAMPUS contractor within 30 days of the date of its request. If records are not received within the designated time frame, authorization of the hospice benefit will be denied and any prior payments made will be recouped. A denial issued for this reason is not an initial determination under Chapter 10, and is not appealable.

**g.** Appeal rights under hospice benefit. A beneficiary or provider is entitled to appeal rights for cases involving a denial of benefits in accordance with the provisions of this Chapter and Chapter 10.

F. BENEFICIARY OR SPONSOR LIABILITY

**1.** General. As stated in the introductory paragraph to this chapter, the Basic Program is essentially a supplemental program to the Uniformed Services direct medical care system. To encourage use of the Uniformed Services direct medical care system wherever its facilities are available and appropriate, the Basic Program benefits are designed so that it is to the financial advantage of a CHAMPUS beneficiary or sponsor to use the direct medical care system. When medical care **is** received from civilian sources, a CHAMPUS beneficiary is responsible for payment of certain deductible and cost-sharing amounts in connection with otherwise covered services and supplies. By statute, this joint financial responsibility between the beneficiary or sponsor and CHAMPUS is more favorable for dependents of active duty members than for other classes of beneficiaries.

**2.** Dependents of active duty members of the Uniformed Services. CHAMPUS beneficiary or sponsor liability set **forth** for dependents of active duty members is as follows:

a. Annual fiscal year deductible for outpatient services and supplies.

(1) For care rendered all eligible beneficiaries prior to April 1, 1991, or when the active duty sponsor's pay grade is E-4 or below, regardless of the date of care:

(a) Individual Deductible: Each beneficiary is liable for the first fifty dollars (\$50.00) of the **CHAMPUS-determined** allowable amount on claims for care provided in the same fiscal year.

(b) Family Deductible: The total deductible amount for all members of a family with the same sponsor during one fiscal year shall not exceed one hundred dollars (\$100.00).

(2) For care rendered on or after April 1, 1991, for all CHAMPUS beneficiaries except dependents of active duty sponsors of pay grades E-4 or below:

(a) Individual Deductible: Each beneficiary is liable for the first one hundred and fifty dollars (\$150.00) of the CHAMPUS-determined allowable **amount** on claims for care provided in the same fiscal year.

(b) Family Deductible: The total deductible amount for all members of a family with the same sponsor during one fiscal year shall not exceed three hundred dollars (\$300.00).

(3) **CHAMPUS-Approved** Ambulatory Surgical Centers or Birthing Centers. No deductible shall be applied to allowable amounts for services or items rendered to active duty or authorized NATO dependents.

(4) Allowable Amount does not exceed Deductible Amount. If fiscal year allowable amounts for two or more beneficiary members of a family total . . . less than \$100.00 (\$300.00 if 2a.(2)(b) above applies), but none of the beneficiary members submit a claim for over \$50.00 (\$150.00 if 2a.(2)(a) above applies), neither the family nor the individual deductible will have been met and no CHAMPUS benefits are payable.

(5) For any family the outpatient deductible amounts will be applied sequentially as the CHAMPUS claims are processed.

(6) If the fiscal year outpatient deductible under either **F.2.a. (1)** or **F.2.a. (2)** above has been met by a beneficiary or a family through the submission of a claim or claims to a CHAMPUS fiscal intermediary in another geographic location from the location where a current **claim** is being submitted, the beneficiary or sponsor must obtain a deductible certificate from the CHAMPUS fiscal intermediary where the applicable beneficiary or family fiscal year deductible was met. Such deductible certificate must be attached to the current claim being submitted for benefits. Failure to obtain a deductible certificate under such circumstances will result in a second beneficiary or family fiscal year deductible being applied. However, this second deductible may be reimbursed once appropriate documentation, as described in this subparagraph **F.2.a. (6)**, is supplied to the CHAMPUS fiscal intermediary applying the second deductible (refer to section A. of Chapter 7 of this Regulation).

(7) Notwithstanding the dates specified in paragraphs **F.2.a. (1)** and **(2)**, in the case of the dependents of active duty members of rank E-5 or above with Persian Gulf conflict service, the deductible shall be the amount specified in paragraph (1) for care rendered prior to October 1, 1991, and the amount specific in

paragraph (2) for care rendered after October 1, 1991. For purposes of the preceding sentence, a member with Persian Gulf conflict service is a member who is, or was entitled to special pay for hostile fire/imminent danger authorized by 37 U.S.C. 310, for services in the Persian Gulf area in connection with Operation Desert Shield or Operation Desert Storm.

1). Inpatient cost-sharing. Except in the case of mental health services (see paragraph F.2.b. (4) of this chapter), dependents of active duty members of the Uniformed Services or their sponsors are responsible for the **payment of the** first \$25 of the allowable institutional costs incurred with each covered inpatient admission to a hospital or other authorized institutional provider (refer to chapter 6), or the amount the beneficiary or sponsor would have been charged had the inpatient care been provided "in a Uniformed Service hospital, whichever is greater.

NOTE : The Secretary of Defense (after consulting with the Secretary of Health and Human Services and the Secretary of Transportation) prescribes the fair charges for inpatient hospital care provided through Uniformed Services medical facilities. This determination is made each fiscal year.

(1) Inpatient cost-sharing payable with each separate inpatient admission. A separate cost-sharing amount (as described in this subsection F.2.) is payable for each inpatient admission to a hospital or other authorized institution, regardless of the purpose of the admission (such as medical or surgical), regardless of the number of times the beneficiary is admitted, and regardless of whether or not the inpatient admissions are for the same or related conditions; except that successive inpatient admissions shall **be** deemed one inpatient confinement for the purpose of computing the inpatient cost-share payable, provided not more than **60** days have elapsed between the successive admissions. However, notwithstanding this provision, all admissions related to a **single** maternity episode shall be considered one confinement, regardless of the number of days between admissions (refer to section B. of this chapter).

(2) Multiple family inpatient admissions. A separate cost-sharing amount is payable for each inpatient admission, regardless of whether or not two **or** more beneficiary members of a family are admitted at the **same time** or from the same cause (such as an accident). A separate beneficiary inpatient cost-sharing amount must be applied for each separate admission on each beneficiary member of the family.

(3) Newborn patient in his or her own right. When a newborn infant remains as an inpatient in his or her own right (usually after the mother is discharged), the newborn child becomes the beneficiary and patient and the extended inpatient stay becomes a separate inpatient admission. In such a situation, a new, separate inpatient cost-sharing amount is applied. If a multiple birth is involved (such as twins or triplets) and two or more newborn infants **become** patients in their own right, a separate inpatient cost-sharing amount must be applied to the inpatient stay for each newborn child who has remained as an inpatient in his or her own right.

(4) Inpatient cost-sharing for mental health services. For care provided on or after October 1, 1995, the inpatient cost-sharing for mental health services is \$20 per day for each day of the inpatient admission. This \$20 per day cost sharing amount applies to admissions to any hospital for mental health services, any residential treatment facility, any substance abuse rehabilitation facility, and any partial hospitalization program providing mental health or substance use- disorder rehabilitation services.

c. Outpatient cost-sharing. Dependents of active duty members of the Uniformed **Services** or their sponsors are responsible for payment of 20 percent of the CHAMPUS-determined allowable cost or charge beyond the annual **fiscal** year deductible amount (as described in paragraph **F.2.a.** of this chapter) for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

d. Ambulatory surgery. Notwithstanding the above provisions pertaining to outpatient cost-sharing, dependents **of** active duty members of the Uniformed Services or their **sponsors** are-responsible for payment of \$2'5 for surgical" care that is authorized and received while in an outpatient status and that has been designated in guidelines issued by the Director, **OCHAMPUS**, or a designee.

e. Psychiatric partial hospitalization services. Institutional and professional services provided under the psychiatric partial hospitalization program authorized by paragraph B.10. of this chapter shall be cost-shared as inpatient services.

3. Retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees. CHAMPUS beneficiary liability set forth for retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees is as follows:

a. Annual fiscal year deductible for outpatient services or supplies. The annual fiscal year deductible for otherwise covered outpatient services or supplies provided retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees, is the same as the annual fiscal year outpatient deductible applicable to dependents of active duty members of rank E-5 or above (refer to paragraph **F.2.a.** (1) or (2) of this chapter).

b. Inpatient cost-sharing. Cost-sharing amounts for inpatient services shall be as follows:

(1) Services subject to the CHAMPUS DRG-based payment system. The **cost-share** shall be the lesser of an amount calculated by multiplying a **per diem** amount for each day of the hospital stay except the day of discharge or 25 percent of the hospital's billed charges. The 'per diem amount shall be calculated so that total cost-sharing amounts for these beneficiaries is equivalent to 25 percent of the CHAMPUS-determined allowable costs for covered services or supplies provided on an inpatient basis by authorized providers. The per diem amount shall be published annually by CHAMPUS.

(2) Services subject to the mental health per diem payment system. The cost-share is dependent upon whether the hospital is paid a hospital-specific per diem or a regional per diem under the provisions of subsection A.2. of Chapter 14. With respect to care paid for on the basis of a hospital-specific per diem, the **cost-share** shall be 25% of the hospital-specific per diem amount. For care, paid for on the basis of a regional per diem, the cost share shall be the lower of a fixed daily amount or 25% of the hospital's billed charges. The fixed daily amount shall be 25% of the per diem adjusted so that total beneficiary cost-shares will equal 25% of total payments under the mental health per diem payment system. This fixed daily amount shall be updated annually and published in the Federal Register along with the per diems published pursuant to subparagraph A.2.d. (2) of Chapter 14.

(3) Other services. For services exempt from the CHAMPUS DRG-based payment system and the CHAMPUS mental health per diem payment system and services provided by institutions other than hospitals, the cost-share shall be 25% of the CHAMPUS-determined allowable charges.

c. Outpatient cost-sharing.

(1) For services other than ambulatory surgery services. Retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees are responsible for payment of 25 percent of the CHAMPUS-determined allowable costs or charges beyond the annual fiscal year deductible amount (as described in paragraph F.2.a. of this chapter) for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

(2) For services subject to the ambulatory surgery payment method. For services **subject** to the ambulatory surgery payment method set forth in Chapter 14 D., of this regulation, the cost share shall be the lesser of: 25 percent of the payment amount provided pursuant to Chapter 14.D.; or 25 percent of the center's billed charges.

d. Psychiatric partial hospitalization services. Institutional and professional services provided under the psychiatric **partial** hospitalization program authorized by paragraph B.10. of this chapter shall be cost-shared as inpatient services.

4. Former spouses. CHAMPUS beneficiary liability set forth for former spouses eligible under the provisions of paragraph B.2.b. of Chapter 3 is as follows:

a. Annual fiscal year deductible for outpatient services or supplies. An eligible former spouse is responsible for the payment of the first \$150 of the **CHAMPUS-determined** reasonable costs or charges for otherwise covered outpatient services or supplies provided in any one fiscal year. (Except for services received prior to April 1, 1991, the deductible amount is \$50.00). The former spouse cannot contribute to, nor benefit from, any family deductible of the member or former member to whom the former spouse was married or of any **CHAMPUS-eligible** children.

b. Inpatient cost-sharing. Eligible former spouses are responsible for the payment of cost-sharing amounts the same as those required for retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees.

c. Outpatient cost-sharing. Eligible former spouses are responsible for payment of 25 percent of the CHAMPUS-determined reasonable costs or charges beyond the annual fiscal year deductible amount for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

5. Cost-Sharing under the Military-Civilian Health Services Partnership Program. Cost-sharing is dependent upon the type of partnership program entered into, whether external or internal. (See section P. of Chapter 1, for general requirements of the Military-Civilian Health Services Partnership Program.)

a. External Partnership Agreement. Authorized costs associated with the use of the civilian facility will be **financed** through CHAMPUS under the normal cost-sharing and reimbursement procedures applicable under CHAMPUS.

b. Internal Partnership Agreement. Beneficiary cost-share under internal agreements will be the same as charges prescribed for care in military treatment facilities.

6. Amounts over CHAMPUS-determined allowable costs or charges. It is the responsibility of the CHAMPUS fiscal intermediary to determine allowable costs for services and supplies provided by hospitals and other institutions and allowable charges for services and supplies provided by physicians, other individual professional providers, and other providers. Such CHAMPUS-determined allowable costs or charges are made in accordance with the provisions of Chapter 14. All CHAMPUS benefits, including calculation of the CHAMPUS or beneficiary cost-sharing amounts, are based on such CHAMPUS-determined allowable costs or charges. The effect on the beneficiary when the billed cost or charge is over the CHAMPUS-determined allowable amount is dependent upon whether or not the applicable claim was submitted on a participating basis on behalf of the beneficiary or submitted directly by the beneficiary on a nonparticipating basis and on whether the claim is for inpatient hospital services subject to the CHAMPUS **DRG-based** payment system. This provision applies to all classes of CHAMPUS beneficiaries.

NOTE : When the provider "forgives" or "waives" any beneficiary liability, such as amounts applicable to the annual fiscal year deductible for outpatient services or supplies, or the inpatient or outpatient cost-sharing as previously set forth in this section, the CHAMPUS-determined allowable charge or cost allowance (whether payable to the CHAMPUS beneficiary or sponsor, or to a participating provider) shall be reduced by the same amount.

a. Participating providers. There are several circumstances under which institutional and individual providers may be Participating Providers, either on a mandatory basis or a voluntary basis. See Chapter 6, A.8. A Participating Provider, whether participating for all claims or on a claim-by-claim basis, must accept the CHAMPUS-determined allowable amount as payment in **full** for the medical



services or supplies provided, and must accept the amount paid by CHAMPUS or the CHAMPUS payment combined with the cost-sharing and deductible amounts paid by or on behalf of the beneficiary as payment in full for the covered medical services or supplies. Therefore, when costs or charges are submitted on a participating basis, the patient is not obligated to pay any amounts disallowed as being over the CHAMPUS-determined allowable cost or charge for authorized services or supplies.

b. Nonparticipating providers. Nonparticipating providers are those providers who do not agree on the CHAMPUS claim form to participate and thereby do not agree to accept the CHAMPUS-determined allowable costs or charges as the full charge. For otherwise covered services and supplies provided by such nonparticipating CHAMPUS providers, payment is made directly to the beneficiary or sponsor and the beneficiary is liable under applicable law for any amounts over the CHAMPUS-determined allowable costs or charges. CHAMPUS shall have no responsibility for any amounts over allowable costs or charges as **determined** by CHAMPUS.

7. [Reserved]

8. Cost-sharing for services provided under special discount arrangements.

a. General rule. With respect to services determined by the Director, OCHAMPUS (or designee) **to be** covered by Chapter 14, section I., the Director, **OCHAMPUS** (or designee) has authority to establish, as an exception to the cost-sharing amount normally required pursuant to this chapter, a different cost-share amount that appropriately reflects the application of the statutory cost-share to the discount arrangement.

b. Specific applications. The following are examples of applications of the general rule; they are not all inclusive.

(1) In the case **of** services provided **by** individual health care professionals and other noninstitutional providers, the cost-share shall be the usual percentage of the CHAMPUS allowable charge determined under Chapter 14, section I.

(2) In the case of services provided by institutional providers normally paid on the basis of a **pre-set** amount (such as **DRG-based** amount under Chapter 14, section A1. or per-diem amount under Chapter 14, section **A.2.**), if the discount rate is lower than the **pre-set** rate, the cost-share amount that would apply for a beneficiary other than an active duty dependent pursuant to the normal **pre-set** rate would be reduced **by** the same percentage by which the **pre-set** rate was reduced in setting **the** discount rate.

9. Waiver of deductible amounts or cost-sharing not allowed.

a. General rule. Because deductible amounts and cost sharing are statutorily mandated, except when specifically authorized by law (as determined by the Director, **OCHAMPUS**), a provider may **not** waive **or** forgive beneficiary liability **for annual deductible** amounts or inpatient or outpatient cost-sharing, as set forth in this chapter.

b. Exception for bad debts. This general rule is not violated in cases in which a provider has made all reasonable attempts to effect collection, without , , , success, and determines in accordance with generally accepted **fiscal** management standards that the beneficiary liability in a particular case is an uncollectible bad debt.

c. Remedies for noncompliance. Potential remedies for noncompliance with this requirement include:

(1) A claim for services regarding which the provider has waived the beneficiary's liability may be disallowed in full, or, alternatively, the amount payable for such a claim may be reduced by the amount of the beneficiary liability waived.

(2) Repeated noncompliance with this requirement is a basis for exclusion of a provider.

#### G. EXCLUSIONS AND LIMITATIONS

In addition to any definitions, requirements, conditions, or limitations enumerated and described in other chapters of this Regulation, the following specifically are excluded from the Basic Program:

1. Not medically or psychologically necessary. Services and supplies that are not medically or psychologically necessary for the diagnosis or treatment of a covered illness (including mental disorder) or injury, for the diagnosis and treatment of pregnancy, or for well-baby care except as provided in the following paragraph.

2. Unnecessary diagnostic tests. X-ray, laboratory, and pathological services and machine diagnostic tests not related to a specific illness or injury or a definitive set of symptoms except for cancer screening mammography and cancer screening **papanicolaou** (PAP) smears provided under the terms and conditions contained in the guidelines adopted by the Director, **OCHAMPUS**.

3. Institutional level of care. Services and supplies related to **in-**patient stays in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care.

4. Diagnostic admission. Services and supplies related to an inpatient admission primarily to perform diagnostic tests, examinations, and procedures that could have been and are performed routinely on an outpatient basis.

NOTE : If it is determined that the diagnostic x-ray, laboratory, and pathological services and machine tests performed during such admission were medically necessary and would have been covered if performed on an **outpatient** basis, CHAMPUS benefits may be extended for such diagnostic procedures only, but cost-sharing will be computed as if performed on an outpatient basis.

5. Unnecessary postpartum inpatient stay, **mother** or newborn. Postpartum inpatient stay of a mother for purposes **of** staying with the newborn infant (usually primarily for the purpose of breast feeding the infant) when the infant (but not the mother) requires the extended stay; or continued inpatient stay of a newborn infant primarily for purposes of remaining with the mother when the mother (but not the newborn infant) requires extended postpartum inpatient stay.

6. Therapeutic absences. Therapeutic absences from an inpatient facility, except when such absences" are specifically included in a treatment plan approved by the Director, OCHAMPUS, or a designee. For cost-sharing provisions refer to Chapter 14, paragraph F.3.

7. Custodial care. Custodial care regardless of where rendered, except as otherwise specifically provided in paragraphs **E.12.b.**, **E.12.c.** and **E.12.d.** of this chapter.

8. Domiciliary care. Inpatient stays primarily for domiciliary care purposes.

9. Rest or rest cures. Inpatient stays primarily for rest or rest cures.

10. Amounts above allowable costs or charges. Costs of services and supplies to the extent amounts billed are over the CHAMPUS determined allowable cost or charge, as provided for in Chapter 14.

11. No legal obligation to pay, no charge would be made. Services or supplies for which the beneficiary or sponsor has no legal obligation to pay; or for which no charge would be made if the beneficiary or sponsor was not eligible under CHAMPUS; or whenever CHAMPUS is a secondary payer for claims subject to the CHAMPUS **DRG-based** payment system, amounts, when combined with the primary payment, which would be in excess of charges (or the amount the provider is obligated to accept as payment in full, if it is less than the charges).

12. Furnished without charge. Services or supplies furnished without charge.

13. Furnished by local, state, or Federal Government. Services and supplies paid for, or eligible for payment, directly or indirectly by a local, state, or Federal Government, except as provided under CHAMPUS, or by government hospitals serving the general public, or medical care provided by a Uniformed Service medical care facility, or benefits provided under title XIX of the Social Security Act (Medicaid) (reference (h)) (refer to Chapter 8 of this Regulation).

14. Study, grant, or research programs. Services and supplies **provided** as a part of or under a scientific or medical **study**, grant, or research program.

15. Not in accordance with accepted standards, experimental or **investigational**. Services and supplies not provided in accordance with accepted professional medical standards; or related to essentially experimental or investigational procedures or treatment regimens.

16. Immediate family, household. Services or supplies provided or prescribed by a member of the beneficiary's immediate family, or a person living in the beneficiary's or sponsor's household.

17. Double coverage. Services and supplies that are (or are eligible to be) payable under another medical insurance or program, either private or governmental, such as coverage through employment or **Medicare** (refer to Chapter 8 of this Regulation).

18. Nonavailability Statement required. Services and supplies provided under circumstances or in geographic locations requiring a Nonavailability Statement (DD Form 1251), when such a statement was not obtained.

19. Preauthorization required. Services or supplies which require **preauthorization** if preauthorization was not obtained. Services and supplies which were not provided according to the terms of the preauthorization. The Director, **OCHAMPUS**, or a designee, may grant an exception to the requirement for **preauthorization** if the services otherwise would be payable except for the failure to obtain preauthorization.

20. Psychoanalysis, or psychotherapy, part of education. Psychoanalysis or psychotherapy provided to a **beneficiary** or any member of the immediate family that is credited towards earning a degree or furtherance of the education or training of a beneficiary or sponsor, regardless of diagnosis or symptoms that may **be** present.

21. Runaways. Inpatient stays primarily to control or detain a runaway child, whether or not admission is to an authorized institution.

22. Services or supplies ordered by a court or other government agency. Services or supplies, including inpatient stays, directed or agreed to by a court or other governmental agency. However, those services and supplies (including inpatient stays) that otherwise are medically or psychologically necessary for the diagnosis or treatment of a covered condition and that otherwise meet all CHAMPUS requirements for coverage are not excluded.

23. Work-related (occupational) disease or injury. Services and supplies required as a result of occupational disease or injury for which any benefits are payable under a worker's compensation or similar law, whether or not such benefits have been applied for or paid; except if benefits provided under such laws are exhausted.

24. Cosmetic, reconstructive, or plastic surgery. Services **and** supplies in connection with cosmetic, reconstructive, or plastic surgery except as specifically provided in subsection E.8. of this chapter.

25. Surgery, psychological reasons. Surgery performed primarily for **psychological** reasons (such as psychogenic).

26. Electrolysis.

27. Dental care. Dental care or oral surgery, except as specifically provided in subsection E.10. of this chapter.

28. Obesity, weight reduction. Services and supplies related to obesity or weight reduction whether surgical **or** nonsurgical; wiring of the jaw or any procedure of similar purpose, regardless of the circumstances under which performed; except that benefits may be provided **for the** gastric bypass, gastric stapling, or **gastroplasty** procedures in connection with morbid obesity as provided in subsection **E.15.** of this chapter.

29. Transsexualism **or** such other c-onditions as gender dysphoria. Services and supplies related to transsexualism or such other conditions as gender dysphoria (including, but not limited, to intersex surgery, psychotherapy, and prescription drugs), except as specifically provided in subsection E.7. of this chapter.

30. Therapy or counseling for sexual **dysfunctions** or sexual inadequacies. Sex therapy, sexual advice, sexual counseling, sex behavior modification, psychotherapy for mental disorders involving sex deviations (e.g., transvestic fetishism), or other similar services, and any supplies provided in connection with therapy for sexual dysfunctions or inadequacies.

31. **Corns, calluses, and toenails.** Removal of corns or calluses or trimming of toenails and other routine podiatry services, except those required as a result of a diagnosed systemic medical disease affecting the lower limbs, such as severe diabetes.

32. Dyslexia.

33. **Surgical sterilization, reversal.** Surgery to reverse surgical sterilization procedures.

34. **Noncoital reproductive procedures including artificial insemination, in-vitro fertilization, gamete intrafallopian transfer and all other such reproductive technologies.** Services and supplies related to artificial insemination (including semen donors and semen banks), in-vitro fertilization, gamete **intrafallopian** transfer and all other **noncoital** reproductive technologies.

35. Nonprescription contraceptives.

36. Tests to determine **paternity or sex of a child.** Diagnostic tests to establish paternity of a child; or tests to determine sex of an unborn child.

37. Preventive care. Preventive care, such as routine, annual, or employment requested physical examinations; routine screening procedures; immunizations; except that the following are not excluded:

a. Well-baby care, including newborn examination, Phenylketonuria (PKU) testing and newborn circumcision.

b. Rabies shots.

c. Tetanus shot following an accidental injury.

d. Rh immune globulin.

e. Genetic tests as specified in paragraph E.3.b. of this chapter.

f. Immunizations and physical examinations provided when required in the . , case of dependents of active duty military personnel who are traveling outside the United States as a result of an active member's duty assignment and such travel is being performed under orders issued by a Uniformed Service.

g. Screening mammography for **asymptomatic** women 35 years **of** age and older when provided under the terms and conditions contained in the guidelines adopted by the Director **OCHAMPUS**.

h. Cancer screening **papanicolaou** (PAP) smear for women who are or have been sexually active, and women 18 years of age and older under the terms and conditions contained in the guidelines adopted **by** the Director, **OCHAMPUS**.

38. Chiropractors and naturopaths. Services of chiropractors and naturopaths whether or not such services **would** be eligible for benefits if rendered **by** an authorized provider.

39. Counseling. Counseling services that are not medically necessary in the treatment of a diagnosed medical condition; for example, educational counseling, vocational counseling, nutritional counseling, counseling for socioeconomic purposes, diabetic self-education programs, stress management, life style modification, etc. Services provided by a certified marriage and family therapist, pastoral or mental health counselor in the treatment of a mental disorder are covered only as specifically provided in Chapter 6. Services provided by alcoholism rehabilitation counselors and certified addiction counselors are covered only when rendered in a CHAMPUS-authorized treatment setting and only when the cost of those '-' services is included in the facility's CHAMPUS-determined allowable cost-rate.

40. Acupuncture. Acupuncture, whether used as a therapeutic agent or as an anesthetic.

41. Hair transplants, wigs, or hairpieces

NOTE : In accordance with Section 744 of the DoD Appropriation Act for 1981 (reference **(o)**), CHAMPUS coverage for wigs or hairpieces is permitted effective December 15, 1980, under the conditions listed below. Continued availability of benefits will depend on the language of the annual DoD Appropriation **Acts**.

a. Benefits provided. Benefits may be extended, in accordance with the CHAMPUS-determined allowable charge, for one wig or hairpiece per beneficiary (lifetime maximum) when the attending physician certifies that alopecia has resulted from treatment of a malignant disease and the beneficiary certifies that a wig or hairpiece has not been obtained previously through the U.S. Government (including the Veterans Administration).

b. Exclusions. The wig or hairpiece benefit does not include coverage for the following:

(1) Alopecia resulting from conditions other than treatment of malignant disease.

(2) Maintenance, wig or hairpiece supplies, or replacement **of the** wig or hairpiece.

(3) Hair transplants or any other surgical procedure involving the attachment of hair or a wig or hairpiece to the scalp.

(4) Any diagnostic or therapeutic method or supply intended to encourage hair regrowth.

42. Education or training. Self-help, academic education or vocational training services and supplies, unless the provisions of Chapter 4, paragraph B.I.e., relating to general or special education, apply.

43. Exercise/Relaxation/Comfort Devices. Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club membership or other such charges or items.

44. Exercise. General exercise programs, even **if** recommended by a physician and regardless of whether or not rendered by an authorized provider. In addition, passive exercises and range of motion exercises also are excluded, except when prescribed by a physician and rendered by a physical therapist concurrent to, and as an integral part **of**, a comprehensive program of physical therapy.

45. Audiologist, speech therapist. Services of an audiologist or speech therapist, except when prescribed by a physician and rendered as a part of treatment addressed to the physical defect itself and not to any educational or occupational deficit.

46. Vision care. Eye exercises or visual training (**orthoptics**).

47. Eye and hearing examinations. Eye and hearing examinations except as specifically provided in paragraph C.2.p. of this chapter or except when rendered in connection with medical or surgical treatment of a covered illness or injury. Vision and hearing screening in connection with well-baby care is not excluded.

48. Prosthetic devices. Prostheses, except artificial limbs and eyes, or if an item is inserted surgically in the body as an integral part of a surgical procedure. **All** dental prostheses are excluded, except for those specifically required in connection with otherwise covered orthodontia directly related to the surgical correction of a cleft palate anomaly.

49. Orthopedic shoes. Orthopedic shoes, arch supports, shoe inserts, and other supportive devices for the feet, including special-ordered, custom-made built-up shoes, or regular shoes later built up.

50. Eyeglasses. Eyeglasses, spectacles, contact lenses, or other optical **devices**, except as specifically provided under subsection E.6. of this chapter.

51. Hearing aids. Hearing aids or other auditory sensory enhancing devices.

52. Telephonic services. Services or advice rendered by telephone or other telephonic device, including remote monitoring, except for **transtelephonic monitoring of** cardiac pacemakers.

53. Air conditioners, humidifiers, dehumidifiers, and purifiers.

54. Elevators or chair lifts.

55. Alterations. Alterations to living spaces or permanent features attached thereto, even when necessary to accommodate installation of covered durable medical equipment or to facilitate entrance or exit.

56. Clothing. Items of clothing or shoes, even if required by virtue of an allergy (such as cotton fabric as against synthetic fabric and vegetable dyed shoes) .

57. Food, food substitutes. Food, food substitutes, vitamins, or other nutritional supplements, including those related to prenatal care.

58. Enuresis. Enuretic devices; enuretic conditioning programs.

59. RESERVED.

60. Autopsy and postmortem.

61. Camping. All camping even though organized for a specific therapeutic purpose (such as diabetic camp or a camp for emotionally disturbed children), and even though offered as a part of an otherwise covered treatment plan or offered through a CHAMPUS-approved facility.

62. Housekeeper, companion. Housekeeping, homemaker, or attendant services; **sitter** or companion.

6 Noncovered condition, unauthorized provider. All services and supplies (including inpatient institutional costs) related to a noncovered condition or treatment, or provided by an unauthorized provider.

64. Comfort or convenience. Personal, comfort, or convenience items such as beauty and barber services, radio, television, and telephone.

65. "stop smoking" programs. Services and supplies related to "stop smoking" regimens.



66. Megavitamin psychiatric therapy, orthomolecular psychiatric therapy.

67. Transportation. All transportation except by ambulance, as specifically provided under **section D.** of this chapter, and except as authorized in subsection E.5. of this chapter.

68. Travel. All travel even though prescribed by a physician and even if its purpose is to obtain medical care, except as specified in subsection A.6.0f this chapter in connection with a CHAMPUS-required physical examination.

69. Institutions. Services and supplies provided by other than a hospital, unless the institution has been approved specifically by **OCHAMPUS**. Nursing homes, intermediate care facilities, halfway houses, homes for the aged, or institutions of similar purpose are excluded from consideration as approved facilities under the Basic Program.

NOTE : In order **to** be approved under CHAMPUS, an institution must, in addition **to** meeting CHAMPUS standards, provide a level of care for which CHAMPUS benefits are payable.

70. Supplemental diagnostic services. Diagnostic services including clinical **laboratory examinations**, x-ray examinations, pathological examinations, **and** machine tests that produce hard-copy results performed by civilian providers at the request of the attending Uniformed Service medical department physician (active duty or civil service).

71. Supplemental consultations. Consultations provided by civilian providers at the request of the attending Uniformed Services medical department physician (active duty or civil service).

72. Inpatient mental health services. Effective for care received **on** or after October 1, 1991, services in excess of 30 days in any fiscal year (or in an admission), in the case of a patient nineteen years of age or older, 45 days in any fiscal year (or in an admission) in the case of a patient under **19** years of age, or 150 days in any fiscal year (or in an admission) in the case of inpatient mental health services provided as residential treatment care, unless coverage for such services is granted by a waiver by the Director, **OCHAMPUS**, or a designee. In cases involving the day limitations, waivers shall be handled in accordance with paragraphs B.8. or B.9. of this chapter. For services prior to October 1, 1991, services in excess of 60 days in any calendar year unless additional coverage is granted by the Director, **OCHAMPUS**, or a designee.

73. Economic interest in connection with mental health admissions. Inpatient mental health services (including both acute care and RTC services) are excluded for care received when a patient is referred to a provider of such services **by** a physician (or other health care professional with authority to admit) **who** has an economic interest in the facility **to** which the patient is **referred**, unless a waiver is granted. Requests for waiver shall be considered under the same procedure **and** based on the same criteria as used for obtaining preadmission authorization (or continued stay authorization for

emergency admissions), with the only additional requirement being that the economic interest be disclosed as part **of** the request. The same reconsideration and appeals procedures that apply to day limit waivers shall also apply to decisions regarding requested waivers of the economic interest exclusion. However, a provider may appeal a reconsidered determination that an economic relationship constitutes an economic interest within the scope of the exclusion to the same extent that a provider may appeal determinations under paragraph 1.3., Chapter 15. This exclusion does not apply to services under the Program for the Handicapped (Chapter 5 of this Regulation) or provided as partial hospital care. If a situation arises where a decision is made to exclude CHAMPUS payment solely on the basis of the provider's economic interest, the normal CHAMPUS appeals process will be available.

74. Not **specifically** listed. Services and supplies not specifically listed as a benefit in this Regulation. This exclusion is not intended to preclude extending benefits for those services or supplies specifically determined to **be** covered within the intent of this Regulation by the Director, **OCHAMPUS**, or a designee, even though not otherwise listed.

NOTE : The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, of itself, **make it medically necessary or make the charge an allowable expense, even though it is not listed specifically as an exclusion.**

#### H. Payment and liability for certain potentially excludable services under the Peer Review Organization program.

1. **Applicability.** This section provides special rules that apply only to services retrospectively determined under the Peer Review Organization (PRO) program (operated pursuant to Chapter 15) to be potentially excludable (in whole or in part) from the Basic Program under section G. of this chapter. Services may be **excluded by reason of being not medically necessary (subsection G.1.) at an inappropriate level (subsection G.3.) custodial care (subsection G.7.) or other reason relative to reasonableness, necessity or appropriateness (which services shall throughout the remainder of this section, be referred to as "not medically necessary").** (Also throughout the remainder of the section, "services" includes items and "provider" includes supplier.) This section does not apply to coverage determinations made by **OCHAMPUS** or the fiscal intermediaries which are not based on medical necessity determinations made under the PRO program.

2. **Payment for certain potentially excludable expenses.** Services determined under the PRO program to be potentially excludable by reason of the exclusions in section G. of this chapter for not medically necessary services will not **be** determined to be excludable if neither the beneficiary to whom the services were provided nor the provider (institutional or individual) who furnished the services knew, or could reasonably have been expected to know, that the services were subject **to** those exclusions. Payment may be made for such services as if the exclusions did not apply.

3. **Liability for certain excludable services.** In any case in which items or services are determined excludable by the PRO program **by** reason of being not

medically necessary and payment may not be made under subsection H.2., above because the requirements of subsection H.2. are not met, the beneficiary may not be held liable (and shall be entitled to a full refund from the provider of the amount excluded and any cost-share amount already paid) if:

a. The beneficiary did not know and could not reasonably have been expected to know that the services were excludable by reason of being not medically necessary; and

b. The provider knew or could reasonably have been expected to know that the items or services were excludable by reason of being not medically necessary.

4. Criteria for determining that beneficiary knew or could reasonably have been expected to have known that services were excludable. A beneficiary who receives services excludable by reason of being not medically necessary will be found to have known that the services were excludable if the beneficiary has been given written notice that the services were excludable or that similar or comparable services provided on a previous occasion were excludable and that notice was given by the OCHAMPUS, CHAMPUS PRO or fiscal intermediary, a group or committee responsible for utilization review for the provider, or the provider who provided the services.

5. Criteria for determining that provider knew or could reasonably have been expected to have known that services were excludable. An institutional or individual provider will be found to have known or been reasonably expected to have known that services were excludable under this section under any one of the following circumstances:

a. The PRO or fiscal intermediary had informed the provider that the services provided were excludable or that similar or reasonably comparable services were excludable.

b. The utilization review group or committee for an institutional provider or the beneficiary's attending physician had informed the provider that the services provided were excludable.

c. The provider had informed the beneficiary that the services were excludable.

d. The provider had received written materials, including notices, manual issuances, bulletins, guides, directives, or other materials, providing notification of PRO screening criteria specific to the condition of the beneficiary. Attending physicians who are members of the medical staff of an institutional provider will be found to have also received written materials provided to the institutional provider.

e. The services that are at issue are the subject of what are generally considered acceptable standards of practice by the local medical community.

f. Preadmission authorization was available but not requested, or concurrent review requirements were not followed.